STATE OF MICHIGAN
IN THE SUPREME COURT

THE ESTATE OF DOROTHY KRUSAC,
deceased by her Personal Representative,
JOHN KRUSAC

Plaintiff-Appellee

Supreme Court No. 149270

-vs-

Court of Appeals No. 321719

COVENANT HEALTHCARE, an assumed name for COVENANT MEDICAL CENTER, INC.; COVENANT MEDICAL CENTER-HARRISON, an assumed name for COVENANT MEDICAL CENTER, INC.; and COVENANT MEDICAL CENTER, INC.

Lower Court No. 12-15433-NH

Defendants-Appellants

/

CYRIL V. WEINER (P76914)
CHARLENE J. REYNOLDS (P55561)
WEINER & ASSOCIATES, PLLC
Attorneys for Plaintiff
4000 Town Center, Suite 550
Southfield, MI 48075
(248) 351-2200

THOMAS R. HALL (P42350)
HALL MATSON, PLC
Attorney for Defendants
1400 Abbot Road, Suite 380
East Lansing, MI 48823
(517) 853-2929

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AMICUS CURIAE BRIEF ON BEHALF OF JEANNE HARRISON

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INTEREST OF *AMICUS CURIAE*

Jeanne Harrison is the Plaintiff in *Harrison v Munson Healthcare, Inc.*, 304 Mich App 1 (2014), and her case is being held in abeyance pending resolution of the instant matter. Decisions made in this matter may have an effect on arguments made by Munson Medical Center and Thomas Hall in their applications for leave to appeal to this Court, which were pending when this Court agreed to grant leave in the instant case. Ms. Harrison obviously has information that may assist this Court in understanding what happens when hospitals think that all information gathered by a hospital employees is confidential and not discoverable, even though the information they seek to hide is does not fall within the confidentiality provisions.

INTRODUCTION

Having been given this opportunity to address this Court, Jeanne Harrison would like to advocate on behalf of herself and on behalf of other patients that have been or will be injured as the result of an untoward event occurring inside a health care facility. Risk managers and department managers in hospitals, surgical centers, outpatient facilities, urgent care facilities, and long term care facilities should not be given absolute power to decide what factual information regarding an untoward event collected for or by them will be placed in a patient's medical record pursuant to MCL 333.20175 (1), and what factual information regarding an untoward event collected for or by them will be placed in an incident report that might possibly be cloaked in confidentiality pursuant to MCL 333.20175 (8) or MCL 333.21515.

This Court, in its order granting leave to appeal in this matter, asked the parties to brief "whether *Harrison v Munson Healthcare, Inc.,* 304 Mich App 1 (2014) erred in its analysis of the scope of the peer review privilege, MCL 333.21515".

First, Ms. Harrison would assert that the unambiguous language of MCL 333.21515 and MCL 333.20175 (8) establishes confidentiality for "records, data, and knowledge collected for or by individuals or committees assigned a review function". MCL 333.21515 and MCL 333.20175 (8) do not establish a peer review privilege for risk managers or department managers; nor do they define a "review function". Ms. Harrison would assert that there must be a "review entity" before there can be "individuals or committees assigned a review function." MCL 333.21513 (d), which immediately precedes MCL 333.21515, provides that the owner, operator and governing body of a hospital "Shall assure that *physicians and dentists* admitted to practice in the hospital are organized into a medical staff to enable an *effective review* of the professional practices in the hospital *for purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients*." (Emphasis added.) That statute does *not* require that hospitals establish a risk management department and empower it with a "review function". The only "individuals or committees assigned a review function" in MCL 333.22513 was the medical staff. MCL 331.531 (2) (a) (iii) defines a "review entity" as "*A duly appointed peer review committee of 1 of the following*". That statute goes on to list various entities including, "*A health facility...*" (Emphasis added.) MCL 331.531 (2) (h) provides that another possible "review entity" would be "*A qualified hospital safety organization that collects data on serious adverse events...*" (Emphasis added.) Nowhere in MCL 331.531 are there any provisions that would directly or indirectly confer "review entity" status on risk managers or department managers. *MCL 331.531 (2) (a) (iii) specifically refers to health facilities covered by*

MCL 333.20175 and MCL 333.21515. As a result "records, data, and knowledge collected" for or by risk managers and department managers cannot be construed as having been "collected for or by individuals or committees assigned a review function" since they are not a "review entity". Even if by some stretch of the imagination, risk managers and department managers were determined to be a "review entity"; MCL 331.532 (1) (f) provides that "the release or publication of a record of the proceedings or of the reports, findings, and conclusions of a review entity shall be for 1 or more of the following purposes:...To comply with section 20175 of the public health code..." (Emphasis added.) MCL 333.20175 (1) specifically provides that, "A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization." *As a result, the "records, data, and knowledge" collected by risk managers and department managers can and arguably must be entered into the patient's chart pursuant to MCL 331.532 (1) (f) and MCL 333.20175 (1).* Still further, MCL 331.533 establishes confidentiality for "the record of a proceeding and reports, findings, and conclusions of a review entity and data collected by or for a review entity under this act are confidential", which is very similar to the confidentiality provisions contained in MCL 333.20175 (8) and MCL 333.21515; however, that MCL 331.533 also created an exception to the confidentiality provisions. Specifically, *MCL 331.533 says that the confidentiality is created "Except as otherwise provided in section 2 [MCL 331.532]", which removes the confidentiality provisions if the information is required to be provided pursuant to MCL 333.20175 (1).* (Emphasis added.)

Second, the language contained in MCL 333.21515 is almost identical to the language contained in MCL 333.20175 (8).

Third, it is remarkable that MCL 333.21515 and 333.20175 (8) could be construed by some to have granted an all-inclusive confidentiality for hospital documents prepared incident to an untoward event; and yet those same statutes could be construed by others to have actually placed significant limitations on what information regarding an untoward event is actually afforded confidentiality. Ms. Harrison would argue that the unambiguous language used by the Legislature: "*collected for or by* individuals or committees *assigned a review function* described in this article" created a significant limitation on the grant of confidentiality in order to ensure that only a very limited amount of the "records, data, and knowledge" collected by a hospital would be shielded from disclosure. (Emphasis added.) If the risk managers and department managers have no "review function", then any incident reports prepared by or for them would not be confidential; and risk managers and department managers would not be able to shield their "records, data, and knowledge" from the patient injured as a result of an untoward event.

This Court must recognize that documents "collected" by or for risk managers and department managers, who do not provide a "review function", should not be afforded the same confidentiality that is afforded documents collected by or for designated peer review individuals and committees, who clearly do provide a "review function". Risk managers and department managers within hospitals do not collect "records, data, and knowledge" in order to provide a "review function". Instead, those individuals or departments simply document untoward events, conduct preliminary investigations, and manage the claims that result. Risk managers and department managers may decide at some point to pass information onto a designated peer review committee so that that committee can decide whether or not to exercise its "review function"; however, until the "records, data, and knowledge" collected for or by a risk manager

or a department manager are actually passed onto a designated peer review committee, the confidentiality protections afforded by MCL 333.21515 and MCL 333.20175 (8) do not apply.

Ms. Harrison and the undersigned were witnesses to how a risk manager and a department manager were able to acquire "records, data, and knowledge" of an untoward event and keep that factual information regarding the untoward event from the patient as they sought to weave a fictitious account of what had occurred. More importantly that factual information regarding that untoward event was not used as part of a "review function". In Judge Rodgers' two written decisions and in the Court of Appeals decision it was revealed how a risk manager and a department manager, aided at times by their legal counsel, could secrete factual information regarding the untoward event by placing that information into various incident reports without also placing that same factual information in the patient's medical record, which was required pursuant to MCL 333.20175 (1) and Munson's internal rules and regulations. The *Harrison* litigation process, Judge Rodgers' *in camera* review of certain documents, and a lengthy evidentiary hearing yielded compelling testimony and critical documents that exposed the dark side of how hospitals hide factual information regarding untoward events into documents they believe to be confidential.

Harrison v Munson, 304 Mich App 1 (2014), in one form or another, has been pending for almost six years. In the *Harrison* case the investigative reports and Munson's internal rules and regulations and in a more limited degree in the *Krusac* case, this Court is able to actually see how the risk managers and the department managers, aided by their legal counsel at times, were able to secrete factual information regarding an untoward event by claiming that the information contained within the documents was confidential pursuant to MCL 333.21515 and MCL 333.20175 (8). In *Harrison* they also purposefully withheld the factual information regarding

the untoward event from Ms. Harrison's medical records despite statutory and in-house rules and regulations that required that the factual information regarding an untoward event be placed in the patient's medical record. In *Krusac* this Court has been given a limited review of the risk management process through the documents that were provided by Covenant in the *Doyle* litigation cited by Covenant in their brief.

The two subparts of MCL 333.20175 are not mutually exclusive. Each of those provisions can be followed, provided that the risk managers, the department managers and their legal counsel realize that both provisions are not mutually exclusive. When Bonnie Schreiber, Munson's risk manager, drafted the hospital's internal rules and regulations she indicated quite clearly that the hospital had a duty to comply with both MCL 333.20175 (1) and (8); however, when an untoward event occurred during surgery on April 24, 2007, Ms. Schreiber chose to comply with MCL 333.20175 (8) and MCL 333.21515 and conceal the factual information of the untoward event contained in an incident report from Ms. Harrison's medical record; and in so doing she failed to make sure that the same factual information of an untoward event entered in the incident report was also placed in Ms. Harrison's medical record pursuant to MCL 333.20175 (1) and the hospital's internal rules regulations. In the instant case, Covenant's internal rules and regulations also pay lip service to MCL 333.20175 (1), but in reality the information contained in that incident report was also not entered into Ms. Krusac's medical record, based upon Judge Borchard's decision to grant plaintiff access to the incident report, despite the provisions of MCL 333.20175 (1) and their internal rules and regulations. (See Exhibit 9.)

There was never a peer review committee investigation conducted in *Harrison* or *Krusac*, nor were there peer review committee hearing processes initiated to address the conduct of the individual or individuals responsible for the untoward events that befell Ms. Harrison and Ms.

Krusac. In *Harrison,* despite the fact that no peer review procedures were ever initiated, Ms. Schreiber, Barbara Peterson, and later Thomas Hall used the confidentiality provisions detailed in MCL 333.21515 and MCL 333.20175 (8) as a shield to conceal the factual information regarding the untoward event from Ms. Harrison contrary to both the provisions of MCL 333.20175 (1) and Munson's internal rules and regulations; and it appears that the Covenant risk manager and Thomas Hall did the same in the instant case.

Unfortunately, if statutorily created confidentiality is expanded to cover risk management and department management functions, instead of being limited to the review functions of a designated peer review committee, abuses are sure to follow. When risk managers and department managers are given the power to control what factual information regarding an untoward event will be placed in the patient's medical record and what factual information regarding an untoward event will be withheld from the patient by placing it in an incident report or other related reports, despite statutory requirements and internal rules and regulations requiring the placement of all relevant facts in the patient's medical record, those same risk managers and department managers will likely choose to use the shield of confidentiality in order to create a more favorable explanation of the untoward event, while keeping the real facts from the patient and out of the court system.

One need only read the written opinions issued by Judge Rodgers, the opinions expressed by Judge Rodgers from the bench, and the Court of Appeals opinion to fully appreciate what risk managers, department managers, and defense attorneys, who do not perform a review function, will do if the factual information regarding an untoward event is given the same confidentiality that was intended to apply to "facts, data, and knowledge" collected for or by a designated peer review committee. (See Exhibits 6 and 7.) If the confidentiality granted by MCL 333.21515 is

expanded to include risk management functions, is it a stretch to imagine that parts of a patient's medical record might be redacted to keep incriminating information from the patient? Given what happened in the *Harrison* litigation, it is hard not to recall the oft quoted statement by Lord Acton, "Power corrupts, and absolute power corrupts absolutely."

Ms. Harrison would also assert that this Court must continue to allow the trial courts to conduct *in camera* reviews of documents claimed to be confidential in order to ascertain whether or not the defenses being proffered by legal counsel are consistent with the shielded information and that the shielded information is consistent with the information placed into the patient's medical record.

STATEMENT OF FACTS

As to facts in the matter before this Court, *amicus* adopts the statement of facts set out in the brief of the Plaintiff Estate of Dorothy Krusac; however, Ms. Harrison believes this Court would benefit from a deeper understanding of the process and method employed by Munson Hospital in her case to prevent the contemporaneous factual information from reaching her, while never submitting it to a peer review committee. Therefore, the following statement of facts regarding the *Harrison* case is offered.

In reviewing the factual scenario detailed below, it may help to know that Ms. Schreiber testified during the evidentiary hearing conducted by Judge Rodgers in the *Harrison* case that she was aware of the contents of the "Quality/Safety Monitoring" report (the incident report) when she was asked to review the discovery responses that were provided to Plaintiff by Mr. Hall. (See Exhibit 1 p.138.)

Ms. Schreiber also testified that she gave the incident report to Mr. Hall and may have given it to the insurance adjuster Ms. Parker as well just before the November trial date. (See Exhibit 1 p.129. The case was originally scheduled for trial in November 2010, but was adjourned to January 2011. Just before the January 2011 trial Ms. Schreiber lost her husband, which helps to clarify when she gave the report to Mr. Hall.) Ms. Schreiber and/or Mr. Hall were aware of the contents of the incident report, the "PEERs Reporting System-Consequences of Event" report (the PEERs report), and/or the "Summary of Complaint/Concern/Compliment" report (the summary report) throughout the litigation process including the trial. (See Exhibits 2, 3, and 4.)

Trial was commenced in the *Harrison* matter on January 12, 2011, before the Honorable Philip E. Rodgers, Jr. in Grand Traverse Circuit Court. Plaintiff claimed that her arm had been inadvertently burned by a Bovie device during a thyroidectomy procedure performed by Dr. Potthoff on April 24, 2007. During the trial Plaintiff called Barbara Peterson, CNOR, BS, who was the Operating Room Manager. Defendants objected asserting that her testimony was not relevant. Plaintiff argued that Ms. Peterson's testimony was relevant, because she had sent a letter to Ms. Harrison dated June 5, 2007, in response to an informal inquiry made by Ms. Harrison herself. (See Exhibit 8.) In that letter Ms. Petersen explained that Munson had conducted a confidential investigation; and after that investigation Munson had implemented two policies intended to prevent such injuries from occurring in the future. Judge Rodgers decided to conduct a *voir dire* examination of the witness before ruling. Judge Rodgers learned during that examination that Ms. Peterson had no recollection of the investigation she had conducted in 2007; however, she stated that she had likely prepared several reports incident to her investigation, which she would have submitted to Ms. Schreiber. Plaintiff then requested that

Judge Rodgers order Mr. Hall to produce reports for an *in camera* review. Judge Rodgers agreed, and he ordered Munson to produce all the reports that had been prepared regarding the burning of Ms. Harrison's arm.

The next day Munson produced the incident report, the PEERs report, and the summary report. After Judge Rodgers reviewed those reports *in camera*, he announced that he was *sua sponte* granting a mistrial, because he did not have time to conduct an evidentiary hearing while keeping the civil trial on hold. From the bench he stated clearly that Munson had misled the plaintiff, her counsel and the court regarding how the untoward event had happened.

Prior to the evidentiary hearing, Munson provided its bylaws and its internal rules and regulations regarding peer review functions, claims handling functions, peer review record keeping, and risk management policies and procedures. (See Exhibit 5.) Those documents clearly provided for firewalls between the risk management functions and peer review functions within the hospital, which will be detailed below.

On March 1, 2011, a day-long evidentiary hearing was conducted both in open court and *in camera*. During the evidentiary hearing Judge Rodgers apparently became convinced that Mr. Hall, who had represented all of the Defendants during the pretrial phase and during the trial phase, was also fully involved in the misconduct that had resulted in the granting of a mistrial. Judge Rodgers concluded that Mr. Hall had advanced a defense that was incompatible with the information contained in the incident report, the PEERs report and the summary report, which he had received more than two months before trial. He believed that Mr. Hall had violated several ethical standards by insisting that no one knew what had happened and that the Bovie had been accidentally pulled out of the holster without Dr. Potthoff having realized it. Judge Rodgers stated in his decision that Mr. Hall's defense strategy was obviously contradicted by the incident

report filed by Ms. Gilliand on April 24, 2007. As a result of that finding, Judge Rodgers sanctioned both Munson and Mr. Hall for their discovery and ethical abuses. (See Exhibit 6.)

Judge Rodgers issued his Decision and Order Regarding Motion for Sanctions on April 8, 2011, in which he ruled that the front page of the incident report was not confidential and that it would be admitted during the retrial. (See Exhibit 6.) He went on to find that Ms. Schreiber and Mr. Hall had abused the discovery process by repeatedly stating that no one knew how the incident had occurred and that they would likely never know how it happened, which Judge Rodgers found was untrue based upon the statements made by Ms. Gilliand in the incident report. Judge Rodgers then detailed how Mr. Hall had violated several ethical provisions found in the Michigan Rules of Professional Conduct by presenting a defense that he had to have known was contrary to the facts detailed in the incident report, the PEERS report and the summary report. Judge Rodgers then sanctioned both Munson and Mr. Hall in the amount of $53,958.00. (See Exhibit 6.)

Munson filed a motion for reconsideration. Judge Rodgers denied reconsideration in his Decision and Order Denying Motion for Reconsideration dated May 4, 2011. In that decision he again took time to severely chastise Munson and Mr. Hall for their misconduct. (See Exhibit 6.)

Munson then filed a motion for stay of proceedings before Judge Rodgers. Following oral arguments on May 23, 2011, Judge Rodgers took still another opportunity to express his anger at what Munson and Mr. Hall had done. (See Exhibit 7.)

Unlike the Plaintiff in *Krusac*, Ms. Harrison was finally able to view the documents that Munson claimed were privileged or confidential, when Defendant Munson decided to appeal Judge Rodgers' decision to impose sanctions. Munson provided those documents to counsel for

Plaintiff when it was obvious that Munson would need to discuss those documents in detail during the appellate process. (See Exhibit 5.)

The information gleaned from the evidentiary hearing, together with the information contained in Munson's internal rules and regulations, clearly demonstrated that Ms. Schreiber and Mr. Hall had concealed critical information, which they believed was confidential, in order to advance a defense that was clearly contrary to the concealed information.

Ms. Schreiber testified during the evidentiary hearing that she was the individual that drafted the "Risk Management-42" section of Munson's internal rules and regulations. (See Exhibit 1 p.95.) In the section setting forth what employees were to do if an untoward event occurred involving an inpatient, outpatient or resident. Item numbered 4 clearly stated that the employee was to "Document the facts of the event in the patient's medical record...document only what is witnessed". The same provisions indicate that the employee was not to indicate that an incident report had been filed; and a copy of the incident report was not to be included in the patient's chart. The same provisions indicated that a PEERs report was also to be prepared documenting the event as soon as possible. The employee was cautioned to "State only facts-what is actually observed or described by witnesses." (See Exhibit 5.) In Ms. Harrison's medical record there was no mention of the fact that the Bovie was "laid on the drape in a fold", nor was there any mention in her medical record that Dr. Potthoff had inadvertently activated the device by leaning on the device while it was between his body and Plaintiff's arm. Still further, there was no mention in her medical record that Dr. Potthoff did not hear the alarm after he inadvertently activated the device and that he needed to be alerted by the surgical techs.

Ms. Schreiber explained that when an incident report comes into Risk Management, it is referred out to whatever individual would be responsible to investigate the incident. Ms.

Schreiber testified that she gave the incident report, the PEERs report and the summary report to Mr. Hall shortly before the trial in the *Harrison* matter. She also indicated that may have given it to the insurance adjuster as well. (See Exhibit 1 p.129.)

On May 23, 2011, during post-trial proceedings, Judge Rodgers was afforded another opportunity to create a record regarding the actions of Munson and Mr. Hall that had resulted in the mistrial and the award of sanctions against both of them.

> "Perhaps the most troublesome part of this case is the ethical issues, and I've made that clear to counsel on both sides from the moment they first appeared in this Court. Perhaps I am a dinosaur, and perhaps as I swear in new attorneys two different times of the year and I ask them to read the oath into the record so they understand the promises they are making to the state, to fellow lawyers, to clients, perhaps that's all a wasted effort, maybe it doesn't matter anymore. But, the notion that one could protect the facts of an untoward event and then present a defense that in this Judge's view is diametrically opposed to them and not have any problem is so repugnant to this Court's sense of justice. I am at a loss how repulsed I am by that argument, how it denigrates our profession....
>
> That is unjust, it is inappropriate and it denigrates the ethics of our profession, which absolutely precludes lawyers from knowingly presenting a false defense. Perhaps we don't live in a world of spin, and black is white and white is black and the sun comes up at night and the moon comes up in the day, we can argue that. As long as we can make the argument and not be humiliated and embarrassed as we stand there in front of a judge or a group of Court of Appeals judges, then I guess it's okay to say what we want to say....
>
> The egregious ethical behavior here is stunning to me, absolutely stunning. But that's a decision ultimately for the Court of Appeals, and I will be instructed if so, I will not be persuaded. And, if things have changed to that degree, if it is so important to the quality of healthcare in this state that we would allow a defense like this to be presented and there never be any cross-examination, we're going to ignore Munson's own internal policy, we're not going to require these facts to be charted, disclosed, reviewed or cross examined we will knowingly present false defenses to the jury because we can spin them, that is a world I don't know." (See Exhibit 7 pp.27-28, 29-30.)

In the instant case Covenant had similar internal rules and regulations regarding the steps that needed to be taken to record facts of an untoward event in the patient's medical record as

well as in the "Improvement Report" (the incident report). The rules and regulations drafted by Covenant are very similar in content to the rules and regulations drafted by Munson and revealed in the *Harrison* litigation. (See Exhibit 9.)

ARGUMENT

HARRISON WAS CORRECTLY DECIDED AND JUDGE BORCHARD WAS CORRECT IN ORDERING THAT THE FACTUAL CONTENTS OF THE IMPROVEMENT REPORT SHOULD BE PROVIDED TO PLAINTIFF

The first issue that needs to be addressed is whether or not factual information regarding an untoward event, especially factual information obtained by health care providers at or near the time of the untoward event, should be shared with the patient by placing the facts of the event in the patient's medical record pursuant to MCL 333.20175 (1). Revealing the facts of an untoward event to the patient, by making an entry in the patient's medical record, and by revealing the same facts to risk manager in an incident report were likely what the Legislature intended when it drafted MCL 333.20175 (1) and (8). That was the position Ms. Schreiber took when she drafted Munson's internal rules and regulations regarding risk management matters. Munson's internal rules and regulations clearly mandated that factual information regarding an untoward event was to be shared with the patient and shared with the risk management staff. The specific provisions of Munson's own internal rules and regulations are as follows:

> "Any person (employee, volunteer, medical staff, contract employee) who identifies an occurrence will:
>
> 1. Provide necessary care and treatment to the patient/resident.
> 2. Notify manager, supervisor, or charge person.
> 3. Notify a physician, if indicated. The time of the notification will depend on the actual or potential affect and circumstances as decided by nurse discretion.
> 4. *Document the facts of the event in the patient's medical record using using forms and documentation procedures as would be done for any other*

problem or deviation from normal or expected parameters.

a. Include date, time, facts of event, and care rendered.

b. Document only what is witnessed; if not witnessed, record: "Patient/visitor states_____".

c. Record assessment and treatment of patient with regard to injury.

d. Record name of physician and family member if notified.

e. If indicated, adjust plan of care to address post-occurrence care needs.

f. Do not document that an occurrence report was completed.

g. Do not keep the original or copy of an occurrence report in the chart.

5. Notify the patient/resident's family member(s) based on degree of injury, prior notice agreements, and nurse of physician discretion.

6. *Enter the occurrence in PEERs as soon as possible following the event. State only facts—what is actually observed or described by witnesses. Paper forms can be used if computer access is not immediately available or if preferred by the reporter.* (See Exhibit 5, "Occurrence Reporting-General" p 2. Emphasis added.)

Those internal rules and regulations were drafted by Ms. Schreiber on behalf of Munson with an eye towards complying with MCL 600.20175 (1) and (8); however, in the *Harrison* matter Ms. Schreiber failed to ensure that the internal rules and regulations were followed by the individuals that witnessed the burning of Ms. Harrison's arm. Ms. Schreiber was quick to make sure that the incident report was forwarded to Ms. Peterson in a timely fashion for an in-house investigation; however, she did not make sure that Ms. Gilliand, the author of the incident report, had entered the facts regarding the untoward event in Ms. Harrison's medical record. In fact, no one that was present in the operating room when the burn occurred made a note in Ms. Harrison's medical record documenting the fact that the patient was inadvertently burned when the Bovie was "laid on the drape in a fold" and that the Bovie was inadvertently activated by Dr. Potthoff when he leaned against it.

According to their own internal rules and regulations and the statutory requirements of MCL 333.20175 (1), Ms. Harrison's medical record was supposed to have contained documentation regarding the untoward events leading up to the injury to her arm. Instead, Ms. Schreiber sought to conceal those facts from Ms. Harrison by claiming that the incident report

and its contents were confidential, despite the requirements detailed in Munson's own rules and regulations.

After it was discovered that the relevant facts of the untoward event had not been recorded in Ms. Harrison's medical record, Ms. Schreiber, with the willing assistance of Munson's insurance carrier and legal counsel, spent almost four years concealing that information from Ms. Harrison and her counsel. At any point in time Ms. Schreiber could have gone to Ms. Gilliand and asked her to make a late entry into Ms. Harrison's medical record detailing the same facts that she had placed in the incident report; however, Ms. Schreiber instead chose to take advantage of the lack of documentation in Ms. Harrison's medical record to create a fiction by stating that no one knew what had happened. Ms. Schreiber's decisions in the *Harrison* matter demonstrated what will happen when risk managers and department managers are given the power to decide what factual information regarding an untoward event will be entered in the patient's medical record pursuant to MCL 333.20175 (1) and what factual information regarding an untoward event will be secreted away in an incident report that might be considered confidential pursuant to MCL 333.20175 (8) or MCL 333.21515.

In reviewing the internal rules and regulations drafted by Covenant in the instant case, it is apparent that both Munson and Covenant were getting their content from the same source. In the rules and regulations provided by Covenant in the *Doyle* case the following excerpts are found:

> "The employee or medical staff involved in, observing, or discovering the incident is responsible for initiating and completing the appropriate sections of the Improvement Report Form. If necessary the supervisor will assist in the completion of the report. Completed forms are to be turned into the department manager immediately.
>
> The information documented in the Improvement Report or collected during the investigation of the incident is protected by Michigan Peer Review Statutes. Care must be taken by all parties involved as to

not destroy this protection.

Comments about the incident should not be discussed in public areas, in front of the patient, visitors or other third parties.

The documentation in the medical record should only reflect the facts and treatment rendered, not that an Improvement Report was filled out.

Improvement reports should not be copied without the consent of Risk Management.

Any extraneous documentation surrounding the event should be turned in and attached to improvement report to maintain peer protection. Items kept in an employee's possession are not protected by statute and will have to be disclosed in a lawsuit. (See Exhibit 9, p.2. Emphasis added.)

The next issue that needs to be addressed is whether or not a risk manager or a risk management department should be considered as an individual or committee assigned a "review function" pursuant to MCL 333.21515. Turning again to Munson's own internal rules and regulations, which were drafted by Ms. Schreiber. The rules and regulations are quite specific regarding the role of the risk manager and the risk management department, "Occurrence reports are retained by the Risk Management Department. They are not to be kept in other departments and *are never made part of a disciplinary action file*." (See Exhibit 5, "Occurrence Reporting-General p.3. Emphasis added.)

Turning now to Munson's internal rules and regulations that address peer review committee records, there is no question that a designated peer review committee performs a review function pursuant to MCL 333.21515. That having been said, in the *Harrison* matter several witnesses testified during the evidentiary hearing stated that no peer review process was ever commenced regarding the inadvertent burning of Ms. Harrison's arm. It is important for this Court to avail itself of the documents that were made available in the *Harrison* matter in order to see how at least one hospital complied with statutory mandates, statutory privileges, and statutes that conferred confidentiality protection.

Munson's internal rules and regulations specifically provided that peer review records "will be secured and any records transported from one location to another will be via authorized representative." Those same rules and regulations listed the individuals or committees that might have access to peer review records if needed, and the risk management department was not one of those entities, except "when practice performance is an issue in an asserted claim." (See Exhibit 5, "Confidentiality of Peer Review Records" pp.1 and 3.) No such situation existed in the *Harrison* matter. There is no dispute that when Munson composed their internal rules and regulations in order to comply with various statutory requirements, they intended that risk management department functions and peer review committee functions would be independent of one another; however, in practice the risk management department sought to cover their activities with the same statutorily created confidentiality provisions that were enacted to shield the peer review committee functions only. Risk management functions did not include a "review function". The term "review function" should be reserved for a duly constituted peer review committee established by a hospital to address complaints filed against specific health care professionals. Risk managers functions are similar to the functions performed by an adjuster within an insurance company. Risk managers receive reports regarding untoward events; they investigate those untoward events; if a claim results, they hand that claim off to the hospital's insurance carrier; and then they oversee and act as the contact person for the insurance adjuster and legal counsel. It is unlikely that the Legislature intended to make risk management functions confidential, since none of the risk management mandates that are detailed in Munson's rules and regulations involved a "review function".

If MCL 333.21515 did grant confidentiality to a risk management department within a hospital, then that confidentiality was waived once the risk manager shared the information with

the hospital's insurance company, with the hospital's legal counsel charged with defending a claim of medical malpractice, or with the patient. As detailed above, Ms. Schreiber and Ms. Peterson shared information with the hospital's negligence attorney, the patient, and possibly with an insurance adjuster. (See Exhibit 1 p.138; and Exhibit 8.)

This Court, when confronted with a claim of privilege or confidentiality by one party, has staunchly defended the opposing party's right to challenge that claim; and this Court has upheld the trial court's right to conduct a thorough *in camera* review of the subject documents. In addition this Court has provided guidance from time to time as to what information can be demanded by the opposing party and by the trial court prior to an *in camera* review.

This Court has held that a party and the trial court are entitled to ask the party claiming a privilege or confidentiality several basic and foundational questions, *i.e.* whether a peer review committee has reviewed the relevant case; when the peer review committee reviewed the relevant case; where the relevant peer review committee conferences were held; who took the notes for the peer review committee proceedings conducted in the relevant case; and who currently has possession of the notes covering the peer review committee proceedings conducted in the relevant case. *Monty v Warren Hospital Corp.*, 422 Mich 138, 146 (1985).

This Court has held that it is incumbent upon the trial court to determine whether the committee or individuals that reviewed the material were in fact assigned a peer review function pursuant to the relevant statutory language and hospital direction, which might require the trial court to examine the hospital's by-laws and internal rules and regulations. *Dorris v Detroit Osteopathic Hospital*, 460 Mich 26, 42 (1999), which was cited as authority this Court's earlier decision in *Monty, supra* pp. 146-147.

This Court held that "hospitals are required to establish peer review committees whose purposes are to reduce morbidity and mortality and to ensure quality of care." *Attorney General v Bruce*, 422 Mich 157, 169 (1985), which was later cited as authority in *Dorris, supra* p. 41:

> "The rationale for protecting the confidentiality of the records, data, and knowledge of such [peer review] committees was set forth in an oft-quoted opinion of the United States District Court for the District of Columbia: 'Confidentiality is essential to effective functioning of these staff meetings; and these staff meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. To subject the discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. *Supra,* pp. 41-42. (Emphasis added.)

This Court in *Feyz v Mercy Memorial Hospital*, 475 Mich 663, 669 n.7 (2006) stated, "It is not clear whether the *ad hoc* investigatory committee and the executive committee were duly authorized 'peer review' entities." This Court went on to hold that actions taken by hospitals generally are ***not*** covered by the peer review statute, specifically MCL 331.531 (3) (b).

> "MCL 33.531 (2) specifically delineates which groups qualify as "review entities" entitled to peer review immunity. While a duly appointed peer review committee of a hospital is a designated review entity under 331.531 (2) (9) (iii), the hospital is not. Therefore, the hospital cannot take advantage of the immunity granted under MCL 331.531 (3) (b), which grants immunity only to review entities for acts or communications within the scope." *Supra,* p. 679 n. 46. (Emphasis added.)

This Court returned to that same issue later in the decision and again explained its clear holding and provided emphasis by repetition:

> "Because of the confusion on this point illustrated by the published peer review Court of Appeals cases, we take this opportunity to clarify that the peer review immunity statute extends only to the communications made, and the participants who make them, in the peer review process, not to the hospital that makes the ultimate decision on staffing credentials.

> Our conclusion is rooted in the language of the immunity statute itself. Nothing in the peer review immunity statute suggests that it applies to any person or entity except those involved in the *communicative* concern of gathering data and evaluating hospital medical practice, as well as those who publish peer review information for the listed proper statutory purposes. It does not apply to the hospital decision maker that might rely upon the work of a peer review committee." *Supra* p. 689.

It should be noted that this Court in *Feyz* emphasized that several Court of Appeals decisions had expanded the peer review immunity beyond the statutory definitions. This Court in *Feyz* clearly separated peer review committees from other hospital committees and held that only peer review committees enjoyed protection from discovery. In the instant case and in *Harrison* the hospitals believed that risk management and department management functions should enjoy the same protections enjoyed by a designated peer review committee; and at the same time they argued in *Harrison* that they had the right to share the confidential information with their insurance carrier and with legal counsel representing them in claims made for medical malpractice. How strange is that position?

This Court was also clear to caution trial courts that "mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection in MCL 333.21515. *Marchand v Henry Ford Hospital*, 398 Mich 163, 168 (1976), and *Monty, supra* pp. 146-147. Munson wrongly argued in *Harrison* that since the risk manager was empowered to turn over information gathered by her department to the designated peer review committee, that information should be shielded by the provisions of MCL 333.20175 (8) and MCL 333.21515.

Ms. Harrison would ask this Court to review the risk management and peer review committee rules and regulations promulgated by Munson in order to better understand the nature and extent of the internal rules and regulations a hospital might draft in order to comply with

statutory mandates. Those internal rules and regulations demonstrate that there was a definite difference between the functions of the risk management department and the functions of the duly constituted peer review committee. (See Exhibit 5.)

The risk management rules and regulations clearly indicated that the Munson's "occurrence reporting system" (the incident report component) was intended as a vehicle to provide data to quality and peer review committees. There is nothing in the statutes or decisions which were cited above that could be construed to have afforded the risk manager or the department manager with such a function. In fact, this Court found such *ad hoc* committees [or departments] to be outside of the privilege afforded peer review committees. *Feyz, supra* p. 669 n. 7. The statutes and case law cited above clearly state that only peer review committees duly constituted by the medical staff should enjoy a statutory privilege and/or confidentiality.

The internal rules and regulations promulgated by Munson in the *Harrison* case also provided the following definition, "An 'occurrence' or 'incident' is any event that is not consistent with normal patient care or visitor safety that either did, or could, directly result in bodily injury or alter the planned course of treatment." Clearly, the "occurrence reporting system" was intended to handle claims management issues exclusively. As such, since the incident reports were requested as part of a claims management process that information fell outside the peer review committee function. This Court in *Monty* clearly stated, "that mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection of the statute." *Monty, supra* pp. 146-147.

Still further, the document defined "occurrence report" as "either a specific paper form or an entry in the electronic system known as PEERs accessed via intranet." Does it make any sense that Munson believed that this report was protected by a peer review committee privilege

or by confidentiality, when the report was actually published on the hospital's "intranet" system where anyone who had access to the system could access peer review documents?

Still further, the incident report required the risk manager, following an initial review, to make a decision "as to the need for immediate follow-up investigation, referral to oversight committee, notice to insurance company, etc." Clearly in the *Harrison* case, the risk manager Ms. Schreiber decided that the incident report needed to be referred to the operating room supervisor Ms. Peterson for an immediate follow-up investigation, rather than to a peer review committee. She clearly determined that this was a risk management/claims management situation that did not require peer review committee oversight. When the subject documents came under scrutiny by the trial court during the *Harrison* trial, Munson asserted that the documents should not be produced because they were part of the peer review committee process and thus confidential; however, when the report was received by Ms. Schreiber in April 2007 she decided to send the matter to Ms. Peterson for an operating room investigation rather than to the Vice President of Medical Affairs for a peer review committee investigation. Ms. Schreiber's actions at the time the event occurred were contrary to the assertions that were made by Munson during trial.

If the above arguments are not sufficient to dispel the hospital's argument that risk management reports should be considered in the same way as peer review committee records, Plaintiff would direct the Court's attention to the "Claims Management-Professional & General Liability" documents that were also provided prior to the evidentiary hearing. (See Exhibit 5 pp 1-2 of the "Claims Management-Professional & General Liability section.) In those internal rules and regulations Munson clearly set up two different claims management processes. One process addressed how cases were to be directed to the peer review committee for investigation,

and the other process addressed how the remainder of the cases should be handled. That document clearly states: "That the Vice President of Medical Affairs (VPMA) monitors the processes of medical staff peer review and complaint management." (See Exhibit 5 p 2 of the "Claims Management-Professional & General Liability section.) Munson in the *Harrison* case argued that the risk manager's investigation was conducted on behalf of the peer review committee, and as such the "records, data, and knowledge" that was gathered was confidential. It is worth noting again that there was no peer review process ever initiated against Dr. Potthoff or any other person present in the operating room on April 24, 2007.

That document clearly establishes two different tracks for claims that were being sent to the Medical Staff (the Vice President of Medical Affairs-VPMA) and those that were handled exclusively by risk management, the Vice President of Legal Affairs-VPLA, the insurance carrier and defense counsel.

It should be noted that Munson's internal rules and regulations stated that, "Claim files and the database contain information that is protected from discovery under the Michigan statutes for quality improvement and peer review and/or as attorney work product. As such, the information is not released without prior approval of the VPLA and generally cannot be released except for a court order." (See Exhibit 5 p 5 of the "Claims Management-Professional & General Liability section.) Again, simply stating that the documents are protected by Michigan statutes does not make it so. Even the drafters of the documents realized that it might be necessary to fall back on "work product" to justify withholding relevant information.

CONCLUSION

Before this Court attempts to deal with the confidentiality and peer review privilege issues raised in *Krusac*, Ms. Harrison would ask that serious consideration be given to what happened in her case, when a risk manager, a department manager, and an attorney believed that the factual information contained in the incident report filed by an eyewitness could be kept from her, even though Munson's internal rules and regulations and MCL 333.20175 (1) mandated that that factual information be entered into her medical record.

It is truly remarkable that Mr. Hall, the attorney that was sanctioned in the *Harrison* case and who has managed the discovery in the *Krusac* case, is on lead asking this Court to reverse several of its prior decisions, which have sought to limit the scope of peer review privilege and confidentiality to duly constituted peer review committees. In *Harrison* it was too easy for Ms. Schreiber and Mr. Hall to shield information from Ms. Harrison and from her counsel, while creating a false factual scenario that turned an absolute liability situation into a defensible claim. The abuses documented above that occurred during the pendency of the *Harrison* case clearly demonstrate why a statutorily created privilege or confidentiality should not be extended to cover the actions of risk managers and department managers.

The Legislature recognized that a patient has a right to be apprised of any facts relating to an untoward event that occurred during a hospital admission. If MCL 333.20175 (1) does not require that the patient be given all of the factual information surrounding an untoward event, then it is safe to assume that hospital risk managers and department managers aided by their legal counsel will do whatever they can to limit patient access to information that may prove that the hospital staff was negligent, which would certainly diminish the quality of patient care in this

state. If that occurs, facts like the ones unearthed in *Harrison* will become the norm, if that hasn't already occurred. Is it unlikely that Mr. Hall is the only defense attorney that has decided that such conduct will enhance his or her reputation.

A unanimous Court of Appeals panel, after having thoroughly examined all of the facts in *Harrison*, held:

> "In affirming the sanctions order against Munson, we emphasize that the the statutory privileges were not intended by the Legislature as licenses to subvert the discovery process, or as shields for the presentation of false or misleading evidence. By protecting peer review from external scrutiny, Michigan's Public Health Code does not concomitantly erect a barrier to a patient's quest for objective facts concerning the patient's own surgical procedure. The discovery process is designed to allow the parties to fully explore the facts underlying a controversy as inexpensively and expeditiously as possible, and without gamesmanship. The peer review statutes do not create an exception to this principle. Nor does any privilege, including that created for peer review, prevent a court from safeguarding the integrity of its administration of justice." *Supra, p.43.*

Judge Rodgers, in his last chance to alert the appellate courts of this state to the dangers of expanding any peer review privilege or confidentiality to include the functions of risk management, said,

> "...if things have changed to that degree, if it is so important to the quality of healthcare in this state that we would allow a defense like this to be presented and there never be any cross-examination, we're going to ignore Munson's own internal policy, we're not going to require these facts to be charted, disclosed, reviewed or cross-examined we will knowingly present false defenses to the jury because we can spin them, that is a world I don't know." (See Exhibit 7.)

What else needs to be said?

RELIEF REQUESTED

Based on the foregoing, the undersigned on behalf of Jeanne Harrison respectfully requests that this Court affirm the circuit court's May 8, 2014, order and remand this case to the Saginaw County Circuit Court for further proceedings.

Respectfully submitted,

Thomas C. Miller (P17786)
Attorney for Jeanne Harrison
P.O. Box 785
Southfield, MI 48037
248-210-3211

Dated: December 3, 2014

EXHIBIT 1

there aren't any. My understanding is, she made notes on the form itself, of what she did to follow-up. And that information came to me with that particular report.

THE COURT: It looked as though several people were interviewed. It just seemed to the Court perhaps notes -- as far as you know, there are no notes --

THE WITNESS: As far as I know, there are no notes, separate from that report.

THE COURT: -- that exist? All right. With regard to this particular report, did you review the report with regard to the hospital's general policies regarding peer review, when any decision was made about releasing the facts?

Let me be more specific.

THE WITNESS: Please.

THE COURT: Exhibit 6. I assume you're familiar with Munson's Risk Management Occurrence Reporting Policy?

THE WITNESS: I wrote it, yes.

THE COURT: All right. Then -- then you crafted the sentence that says that the facts of the event are to be documented in the patient's medical record?

THE WITNESS: Correct.

THE COURT: What forms were you referring to? Using forms and document procedures. What forms?

THE WITNESS: All of the various chart forms. When it's on paper, it's enumerable forms. That's how a chart ends up yay thick(indicating) for a one day procedure. Any form that would normally be used to document patient care. It could have been the OR record. Could be the dictated notes Dr. Potthoff made. Progress notes. Any form that's a medical record form.

THE COURT: This seems to be not in input/output form or medication forms. This talks about forms and documentation procedures that as would be done for any other problem or deviation for normal or expected parameters.

Is there a form used to document problems or deviations from normal or expected parameters, that's supposed to go in the patient's chart?

THE WITNESS: Nothing that's specifically entitled that, no. That paragraph was intended to tell the staff to use all the chart forms you normally would, to document what happened to the patient.

to the insurance adjuster?

A No.

Q You sure?

A I'm pretty sure I didn't. I know we gave it to Mr. Hall just before trial, in that process. But I don't know if --

Q Are --

A -- if it was given to Mrs. Parker.

Q -- are you sure you gave it to him just before trial?

A I can't tell you timing. I could probably figure it out. But it was shortly before trial date. It was not in the process of discovery.

Q And -- and again -- I don't want to bring up the tragedy that happened within your family. But was it before that?

A Very likely.

Q In other words, you left work because of that tragedy, right?

A Yes.

Q So you had your conversations with Mr. Hall and gave him the incident report before that date?

A Yes.

Q When you -- when you reviewed the discovery requests that I sent to Mr. Hall on behalf of -- to -- to be answered by Munson, did you know what was in the

A Absolutely.

Q And I should -- should indicate that those were supplemental answers to the second set of interrogatories, what was Exhibit Number 20. Do you believe that the answers that -- that you approved -- and can I be -- you did say those were okay to put in there, right?

A I recall Mr. Hall asking me every turn of events, if these answers were correct. I did not sign them.

Q All right. But you -- you were questioned each time, whether they were okay?

A That is my recollection, yes.

Q And do you believe all those answers that I've shown you were consistent with what you knew to exist in the incident report?

A Yes.

Q When did you -- when did you find out for the first time that Ms. Tembreull knew how the incident had occurred?

MR. HALL: Objection to the form. When he says how the incident occurred. In fairness to all -- and this strikes to the heart of this matter and our defense. What -- can Mr. Miller please define for the witness what he means by Ms. Tembreull allegedly testifying, either at deposition or at

EXHIBIT 2

MUNSON HEALTHCARE

RECEIVED JUL 0 2 2007 BY: Rm/LP

QUALITY/SAFETY MONITORING

JFORM 802 (01/03)

Patient name and U number: 80-17-56 HARRISON,JEANNE A M0710301087 F 06/25/49 57Y 04/24/07 POTTHOFF,WILL

SEE REVERSE SIDE FOR TYPES OF EVENTS TO REPORT AND OPTIONAL CHECK BOX FORMAT

Please use check box section on back for Pt. falls and med errors. These contribute better data to the Process Improvement Program.

DO NOT: (a) Reference completion of report in medical record; (b) Store report in medical record; (c) Duplicate report without authorization

Patient type: ☐ Inpatient ☒ Outpatient ☐ ED ☐ LTC ☐ Not related to a specific patient

WHERE? Department/Location: OR Rm 9

OTHER DEPT. INVOLVED? Other Department/Location involved: no — Route this form to other dept. involved before returning to Risk Management.

WHEN? Occurrence Date/Time: 4/24/07 Around 1220 — Discovery Date/Time: and/or Date of Report: 4/24/07 @ 1351

WHAT happened? What needed to be done? **HOW** was the patient affected? How was the situation identified?

☒ ACTUAL ☐ NEAR MISS

During procedure bovie was laid on drape, in a fold. Dr. Potthoff was leaning against the pt where the bovie was. Ann Tembrell baker Student noticed a burn in the drape. Bovie tip was replaced and a towel placed over the hole in the drape. At end of case after drapes removed a 3rd degree burn about 6-7 mm stated by Dr. Potthoff.

Bovie setting on Low tone

Who was ST? Babcock Nichole

Dwight Lindhorst Cindy Gilliand

TREATMENT REQUIRED

☐ Received Pain Med ☐ Need for Additional Care/Procedures
☐ Received First Aid ☐ Added Length of Stay
☐ Increased Monitoring (VS, labs) ☐ Transfer to Specialized Unit (ICU, CCU)

WHO was notified? If fall, notify family ASAP.

Physician notified: ______ ☐ N/A (Date/Time) ______

Family notified: ______ ☐ N/A (Date/Time) ______

Supervisor notified: ______ ☐ N/A (Date/Time) ______

Send completed form to Risk Management

Optional Check Box Format

Types of events to report and reminders of info to include in description

GENERAL OCCURRENCES (refer to policy 42.04)

Fall:
- ☐ While walking/standing
- ☐ From Chair/Wheelchair
- ☐ From Commode/Toilet
- ☐ From Bed/Stretcher/Table

Patient gender ☐ Male ☐ Female

Fall observed by staff? ☐ Yes ☐ No

Fall assisted/lowered to floor? ☐ Yes ☐ No

Prior risk assessment? Points ______ ☐ No

Recent risk assessment = patient at risk? Points ______ ☐ No

Fall precautions implemented before fall? ☐ Yes ☐ No

Restraints/side rails in use at time? ☐ Yes ☐ No

Procedure/Treatment Related:
- ☐ Omission
- ☐ Delay/Wrong Time
- ☐ Documentation
- ☐ Wrong Patient
- ☐ Wrong Procedure
- ☐ Consent Related
- ☐ Surgical Count Discrepancy
- ☐ Performed Incorrectly
- ☐ Unexpected Complication
- ☐ Injury During Transport
- ☐ Injury During Treatment
- ☐ Other ______

Procedure/Tx Occur due to:
- ☐ Order Transcription Error
- ☐ Communication
- ☐ Other ______

Equipment/Device Related:
- ☐ Malfunction
- ☐ Electric Shock
- ☐ Fire/Smoke
- ☐ Availability
- ☐ Contaminated
- ☐ Improper Use
- ☐ Defect
- ☐ Explant
- ☐ Other ______

[Save It and notify Risk Management - refer to policy 42.13]

Miscellaneous:
- ☐ Injury
- ☐ Self-Inflicted Injury
- ☐ Injury By Another
- ☐ Verbal/Physical harassment
- ☐ Suspected Abuse/Neglect
- ☐ Left AMA or Elopement
- ☐ Left Before Evaluation
- ☐ Confidentiality Breach
- ☐ Non-Compliance
- ☐ Lost/Damaged Property
- ☐ Dissatisfaction with care or services
- ☐ Other ______

Known Extent of Injury:
- ☐ Abrasion/Laceration/ Skin tear/Puncture
- ☐ Bruise/Hematoma
- ☐ Sprain/Strain
- ☐ Fracture/Dislocation
- ☐ Soft tissue trauma
- ☐ Aspiation/Respiratory affect
- ☐ Cardiac and/or Respiratory Arrest
- ☐ Aggravated Pre-Existing Condition
- ☐ Systemic Reaction/Response
- ☐ Change in LOC
- ☐ Blood Loss
- ☐ Burn
- ☐ Possible Infection
- ☐ No Apparent Injury
- ☐ to ED for treatment/eval
- ☐ Refused treatment/eval
- ☐ Death
- ☐ Other ______

NON-PATIENT RELATED (refer to policy 42.05) SYSTEMS or COMMUNICATION ISSUES

- ☐ safety - near miss exposure or injury
- ☐ safety - general violation
- ☐ regulatory compliance
- ☐ confidentiality
- ☐ other ______
- ☐ security issue
- ☐ policy compliance
- ☐ staff behavior
- ☐ communication

SAVE IT! Save device and packaging. Call Risk Management (56774) to pick up.

MEDICATION ERRORS (refer to policy 61.81)

______ Name of med(s) ______ route

- ☐ omission
- ☐ wrong pt
- ☐ wrong drug
- ☐ wrong dose
- ☐ wrong route
- ☐ wrong rate
- ☐ wrong time
- ☐ discontinued med given
- ☐ expired med given
- ☐ extra dose
- ☐ unordered drug
- ☐ wrong choice prescribing
- ☐ other ______

Was error: ☐ Missed at MAR to MAR check ☐ Discovered at MAR to MAR check

First stage in process where error occurred:
- ☐ Prescription
- ☐ Pharmacy Dispensing
- ☐ Nursing Transcription
- ☐ Medication Administration
- ☐ Pharmacy Transcription
- ☐ Documentation
- ☐ Other ______

MANAGER/OTHER DEPT. AND/OR RISK MANAGEMENT FOLLOW-UP/COMMENTS:

☐ None Required ☐ To QI/Peer Review Team ☐ Claim File Opened

Reviewed @ Wed inservice. Reviewed use of Cautery safety devices. Use of these devices was made a "Red Rule" resulting in disciplinary action if safety devices not used. Bovie holder was on field for this case, however bovie was not placed in it.

SL 4

Signatures: B. [illegible] Date: 5/9/07

EXHIBIT 3

PEERS Potential Error/Event Reporting System

Confidential - for peer review and quality improvement under applicable state law

your feedback is appreciated

Report Status: Closed

Update Report Status: Closed | Save | Return to Report List | Link This Report | Assign This Report | View Linked | View All Assigned

Report ID: 194555 | **Date of Report:** JUL 10,2007 13:40 | **Reporter:** | **Title:** Risk Manager | **Anonymous:** Y

General Info CLARIFY

Department	OR
MO-Specific Location	OR
Date of Event	APR 24,2007
Time of Event	1220
Date aware of this event	APR 24,2007
Time aware of this event	1351
Date of Report	JUL 10,2007 1340

Event Category CLARIFY

Event Category	Injury Other Than Sharps or Slip/Fall
Type of Injury?	_Other
Activity at time of injury	patient undergoing surgery
Secondary Event Category	
Tertiary Event Category	
Event Severity Level	JUL 11, 2007 07:34 User: scook1 4) Event - patient monitored &/or treated to preclude harm

Situation Information CLARIFY

Contributing Factor #1	Failure to follow procedure/policy
Contributing Factor #2	_Not applicable

Consequences of Event CLARIFY

Actual Impacts	Y Burn, scald
Who was at risk?	Patient
Affected Person Name	Jeanne A Harrison
Patient Bed/Unit/Dept	OR 9
Patient Med Rec No	801756

Description

To summarize reporter's written statement, the patient suffered a 3rd-degree burn about 6-7mm because the Bovie was not properly placed and burned a hole in the drape.

Action Taken CLARIFY

w was the event or potential event ntified?	Other employee/physician
Was the physician notified?	Yes
Name of physician notified:	Potthoff

If Yes, Date Physician Notified:	APR 24,2007
If Yes, Time physician notified:	1351
Was this event disclosed to the patient/family?	_Unknown
Identify Additional Action Taken	
Identify As a result of this report	

Prevention

Comments Risk Mgr. | General | Pharmacy

List of assigned user	
Risk Manager's Comments	
General Comments 1	JUL 11, 2007 07:33 User: scook1 On file in RM is the paper report rec'd 07/02/07, signed by B. Peterson on 05/09/07 and noted "Reviewed at Wed. Inservice. Reviewed use of cautery safety devices. Use of these devices was made a "red rule" resulting in disciplinary action if safety devices not used. Bovie holder was on field for this case, however bovie was not placed in it."
General Comments 2	
General Comments 3	
General Comments 4	
General Comments 5	
General Comments 6	
General Comments 7	
Identify the drug class involved in the report	
Identify the drug class 2 involved in the report	
During what phase did the event / error / close call occur?	
Pharmacy General Comments	

Return to Report List | Link This Report | Assign This Report | View Linked | View All Assigned

EXHIBIT 4

Summary of Complaint/Concern/Compliment
File ID: 1817
Submission Date: 06/05/2007

Person Information

Last Name: HARRISON
First Name: JEANNE
MRN: 801756
Sex: F
DOB: 06/25/1949
Age: 57 year(s)
Street1: 3589 hunters rd
City: luzerne
State: michigan
ZIP: 48636
Phone: 989-826-5701
Relation: Self

Issue List

- **Incident Date: Tuesday, April 24, 2007**

Classification: Grievance > Major

Description:

patient was to have thyroid removed for cancer. during removal, a tool used for cauterizing was resting on her arm and was inadvertently turned on causing a partial thickness burn about the size of a quarter. dr. Pothoff went out and told jeanne's husband and they proceeded to debride the burn. Jeanne wants to be assured that whatever process broke down, that it will be corrected so it doesn't happen to someone else.

Issue About:

Location

Site: MMC
Department: OR

Categories:

- Care/Treatment > Unexpected outcome or injury incurred during care

Details

File ID: 1817
Entered Date: 06/05/2007
Entered Time: 13:10
Entered By: Lueck, Tim
Submission Date: 06/05/2007
Method: Telephone
File Owner: Lueck, Tim (PL)

Desired Outcome:

- Acknowledgement
- Notice to Admin/Dir/Mgr

Set Up Time & Attachment

Setup Time: 40 (minutes)

Followup List

- **Referral to Manager/Director/Administrator by Lueck, Tim to B Peterson on Wednesday, June 06, 2007**

Followup Method: E-Mail
Followup Description:
Barb, I'm sending you a summary of a patient that was burned during surgery. she would like a letter sent to her how processes have been improved so that his instance won't happen to anyone else. feel free to forward this letter to me and I will send it to the patient. thank you
Followup Time Spent: 25 (minutes)

Response/feedback to pt/complainant by peterson,Barb to Harrison,Jeanne on Tuesday, June 12, 2007

Followup Method: Letter
Followup Time Spent: 30 (minutes)
Followup Attachment:
harrison response letter.doc

Response/feedback to pt/complainant by SCHREIBER BONNIE to Mrs Harrison & atty on Monday, July 21, 2008

Followup Method: Letter

Followup Description:
attached letter rec'd. Claim opened and routed to Insurance Rep
Followup Time Spent: 20 (minutes)
Followup Attachment:

- atty letter.pdf

- **Patient/Family Conference by SCHREIBER BONNIE to J Harrison on Thursday, July 31, 2008**

Followup Method: In Person
Followup Description:
met with Jeanne- she showed me the burn scar. Pics taken
She described burn healing as longer and more painful than her thyroid surgery. Scar continues to bother her as it hurts when exposed to sunlight. States has made her anxious about having more surgery.
I offered a plastic surgeon consult for eval of what could be done for scar, not necessarily operate on it- "not interested".
I told her I'd get back with Mr Miller to figure out what we could do.
Followup Time Spent: 45 (minutes)
Followup Attachment:

- Pics.doc

- **Resolution offer/demand response by SCHREIBER BONNIE to atty Miller on Wednesday, February 11, 2009**

Followup Method: Telephone
Followup Description:
see attached letter

call to office = no to $60,000 Dr P is not employee. "I guess I'll need to sue".

file closed- move to claims, MHAIC notice sent
Followup Time Spent: 20 (minutes)
Followup Attachment:

- Demand letter.pdf

Linked Files
None.

...esolution
Resolution Date: 08/18/2008
Total Time: 180 (minutes)
Resolution Summary:

- Apology
- Improved Care for Others
- Event Does not Happen Again
- Noted Admin/Dir/Mgr
- RM consult/advised

Resolution Notes:
closed as grievance- see claim file #59
File Status: Closed/Resolved

If you require assistance with this application, call 20189

EXHIBIT 5

MUNSON HEALTHCARE Your Health... Our Mission	Risk Management - 42	
	Policy Name:	Occurrence Reporting - General
	Policy ID Number:	042.P004
	Start Date:	09/01/2005
	Approval Date:	09/07/2005
	Approved by:	Sheila Atwood, Debbie Link, Bonnie Schreiber

Header Information
Document Body

(Refer to Employee Incident Reporting policy for employee injuries)

Munson Healthcare facilities and services utilize an occurrence reporting system to:

- Provide concise documentation of a reportable event,
- Provide data to quality and peer review committees to assist in identification of trends and assessment of opportunities for continuous quality improvement,
- Promote prompt investigation and intervention to mitigate injury or loss in individual occurrences.

An *"occurrence"* or *"incident"* is any event that is not consistent with normal patient care or visitor safety that either did, or could, directly result in bodily injury or alter the planned course of treatment.

A *"reportable event"* includes, but is not limited to: falls, medication errors, equipment malfunction, treatment delays, burns, noncompliance, suspected abuse or neglect, complaints, property damage/loss, procedural errors, etc.

An "*occurrence report*" describes either a specific paper form or an entry in the electronic system known as PEERs (Potential Error/Event Reporting system) accessed via Intranet.

Inpatient, Outpatient, or Resident

Any person (employee, volunteer, medical staff, contract employee) who identifies an occurrence will:

1. Provide necessary care and treatment to the patient/resident.
2. Notify manager, supervisor, or charge person.
3. Notify a physician, if indicated. The time of the notification will depend on the actual or potential patient affect and circumstances as decided by

nurse discretion.

4. Document the facts of the event in the patient's medical record using forms and documentation procedures as would be done for any other problem or deviation from normal or expected parameters.

a. Include date, time, facts of event, and care rendered.

b. Document only what is witnessed; if not witnessed, record: "Patient/visitor states _____".

c. Record assessment and treatment of patient with regard to injury.

d. Record name of physician and family member if notified.

e. If indicated, adjust plan of care to address post-occurrence care needs.

f. Do *not* document that an occurrence report was completed.

g. Do *not* keep the original or copy of an occurrence report in the chart.

5. Notify the patient/resident's family member(s) based on degree of injury, prior notice agreements, and nurse or physician discretion.

6. Enter the occurrence in PEERs as soon as possible following the event. State only facts–what is actually observed or described by witnesses. Paper forms can be used if computer access is not immediately available or if preferred by the reporter.

Visitor

Any person who identifies an occurrence or assists an injured visitor will:

1. Render care and assistance to the visitor or seek help to assess degree of injury.

2. Arrange transport to the Emergency Department. If visitor refuses ED evaluation, document their statement on the accident report.

3. Enter the event in PEERs or initiate a Visitor Accident Report (Form 3627) to document facts of occurrence.
At Munson Medical Center, page Security. The officer will complete the Visitor Accident form and initiate investigation and follow up, as the situation indicates. Security will also take photographs.

4. The completed accident report is sent directly to Risk Management. It is not made part of the ED record.

GENERAL GUIDELINES

Managers, supervisors or persons in charge are responsible for ensuring that an occurrence report is complete and for documenting any follow-up information obtained.

Occurrence reports should contain sufficient information to provide for initial analysis. Staff do not need to enter their name (or sign the report) if they wish to remain anonymous. Anonymous reporting is also possible by making a verbal report directly to Risk Management.

Paper report forms should be routed to the Risk Management Department as soon as manager follow-up is possible, preferably within 48 hours of the event.

Risk Management should be immediately notified when an event results in a serious injury/illness to a patient or visitor so that an investigation of the events can take place as soon as possible. No investigation of serious occurrences or statements from witnesses should be undertaken without expressed direction of Risk Management.

The medical record should contain only facts of the event. *Never document that an occurrence report has been completed nor refer to such report in the patient's chart.*

Copies of the report should *not* be made unless directed to do so by Risk Management.

Occurrence reports are retained by the Risk Management Department. They are *not* to be kept in other departments and are never made part of a disciplinary action file.

If the occurrence involves medical equipment or devices, save all parts and packaging–follow policy on Medical Equipment/Device Reporting.

Charges for care and treatment related to an occurrence are processed per normal cost accounting mechanisms. Notify Risk Management if there are charges that should be adjusted. Charges for ED evaluation and treatment of injured visitors are paid under the General Liability Insurance Plan if appropriately reported to Risk Management and at the discretion of Administration.

Risk Management Department Role/Responsibilities

All general/medication occurrence and visitor accident reports are reviewed by the Risk Management staff. Each is assessed for loss potential by considering degree of injury, necessary treatment, costs incurred, patient response, care standards, etc. Based on initial review, a decision is made as to need for immediate follow-up investigation, referral to oversight committee, notice to insurance company, etc.

The Risk Management Department maintains the database of occurrences and provides aggregate data for review, trend identification, and action

plan development to appropriate oversight committees (Board Quality, Safety Committee, Dept./Unit CQI, Medical Staff Quality/Peer Review, Quality Counsel, Medication Occurrence Review, etc.). Reports from the database are generated monthly, quarterly, or annually as needed. The board of trustees/directors receives information on occurrence data, trends, and individual event management at least quarterly.

Events that result in actual or potentially serious injury are investigated. If claim/litigation potential exists, the event and investigation results are reported to the appropriate review committee, Corporate General Counsel, the administrator/director/manager of departments involved, and to the appropriate insurance carriers. Patient Accounts is notified of any decisions related to billing adjustment.

Occurrence reports are confidential documents used for continuous quality improvement and peer review. Occurrence reports are maintained in secure files in the Risk Management Department. Each individual report, and all summary reports of occurrence data, are confidential per applicable Michigan peer review protection statutes.

Visitor accident reports are not considered to be peer review documents but may be protected under the attorney-client privilege statutes. Accident reports are copied and released only by written request and as directed by the Vice President of Legal Affairs.

Employees and physicians are educated regarding the requirements of this policy and procedure during orientation and periodically as policy, legal, or form changes occur and as needs are identified through review and trending of reports by Risk Management or quality/peer review committees.

MUNSON HEALTHCARE Your Health...Our Mission	Medical Staff - 19	
	Policy Name:	Confidentiality of Peer Review Records
	Policy ID Number:	019.030
	Start Date:	08/18/2005
	Approval Date:	08/18/2005
	Approved by:	MEC 8
	Last Reviewed On:	11/17/2008

Header Information

Document Type: Policy

Policy		Deployment	
Policy Name:	Confidentiality of Peer Review Records	Institution:	Munson Healthcare
Supercedes:		Division:	Munson Healthcare (All)
Level:	Revised	Department:	Medical Staff - 19
Owner(s):	Kim Mckinley/Domino	Contributing Departments:	
Priority:		Manual Name:	
Identification Number:	019.030	Manual Category / Chapter:	
Status:	4. Approved	Restricted to Groups:	
Approval Date:	08/18/2005	Start Date:	08/18/2005
Version Number:	3	Monthly Review Interval:	36
Last Reviewed On:	11/17/2008	Review Date:	11/17/2011

Document Body

Munson Healthcare recognizes that it is vital to maintain the confidentiality of Peer Review Records for reasons of law and policy. Medical Staff members regularly participate in credentialing, peer review and quality assurance activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. All Practitioners understand that the confidentiality of these activities, and Peer Review Records, is to be preserved and that Peer Review Records will be disclosed only in furtherance of credentialing, peer review and quality assurance activities, and only as permitted under the conditions described in this Policy.

All Peer Review Records will be maintained within Munson Medical Center in areas designated and approved by the Medical Staff, Hospital Administration and Hospital Legal Counsel. Designated peer review areas, will be secured and y records transported from one location to another will be via authorized presentative. Peer Review Records will only be released to other individuals/sites in accordance with this Policy.

DEFINITIONS

DEFINITIONS: For the purposes of this process, a Peer Reviewer shall be defined as a licensed member of the medical staff and/or health care provider and/or designated subcommittee (e.g., one or more members of a section) or ad hoc group, any of whom are charged with reviewing care provided at the hospital. Opinions and reviews from medical staff members, in the same specialty as the individual whose case is under review and other specialties may be solicited and considered, regarding specific issues related to the management of the case under review. An individual functioning as a peer reviewer cannot be the practitioner in question. Opinions and information may be obtained from participants who were involved in the patient's care

The following definitions apply with respect to this Policy:

Practitioner means all applicants to, or members of, the Medical Staff, all categories of Allied Health Professionals, and other professionals considered for, or awarded, clinical privileges at the Hospital.

Hospital means Munson Healthcare Affiliated Hospitals (Munson Medical Center, Paul Oliver Memorial Hospital, Leelanau Memorial Health Center, Kalkaska Memorial Health Center).

Peer Review Records means all records of Application, Credentialing, the consideration and award of Clinical Privileges, Proctoring, Quality Assurance, Corrective Action, Fair Hearing, Probational, Disciplinary and other records assembled to assess the qualifications, evaluation, re-evaluation, and performance of Practitioners, maintained by the Medical Staff office, committees of the Medical Staff, Department and Sections, committees of the Board and by the Board, pertaining to individual Practitioners, Departments or Sections.

Peer Review Records include memoranda, minutes, telephone logs, medical records, tapes, photographs, exhibits, and other related documents, and also includes oral discussions and deliberations incorporated by implication or reference into Peer Review Records. Also see Policy 19.61 for a more specific definition of peer review cases.

Peer Review Records do not include individual demographics, such as name, address, status of Medical Staff membership or Allied Health Professional membership, or the medical specialty of individual practitioners. Reports and activities of the Medical Staff, information or educational in nature, published in general Medical Staff minutes, notes or bulletins, or in CME documents, are not Peer Review Records.

Medical Staff means the organized Medical Staff of the Hospital.

Organizational Documents means the Bylaws, Credentials Policy and Procedure Manual, Rules & Regulations and Policies of the Medical Staff and the Hospital.

Board means the Board of Trustees of the Munson Healthcare Hospitals

ACCESS BY PERSONS WITHIN THE HOSPITAL AND MEDICAL STAFF

Means of Access

All requests for Peer Review Records shall be presented to the Medical Staff Manager in writing. Requests which require notice to, or approval by, other officials shall be forwarded to those persons by the Medical Staff Manager. A person permitted access under this paragraph shall be given a reasonable opportunity to inspect the records in question and to make notes regarding them, but will not be allowed to remove them from the Medical Staff Office, or to have copies made, except as otherwise specifically provided by this Policy.

Access by Persons Performing Official Hospital or Medical Staff Functions

Medical Staff Officers, Vice President of Medical Affairs, Chiefs of Medical Staff Departments or Section, Medical Staff Committee members, members of Board Committees charged with Quality Management, designated consultants, the Medical Staff Coordinator, the Chief Executive Officer or his authorized representatives, and other persons assisting in credentialing, peer review or quality assurance activities will have access to Peer Review Records, other than their own, only to the extent necessary to perform their functions. More particularly:

A. Medical Staff President , President-Elect and Liaison Officer, shall have access to Peer Review Records.

B. Department or Section Chiefs shall have access to all Peer Review Records pertaining to the activities of members of their respective Departments or Section, and of Allied Health Professional assigned to such Departments or Sections for credentialing or peer review.

C. Medical Staff Committee Members shall have access to the Peer Review Records of committees on which they serve and, when necessary, to fulfill their responsibilities under the Medical Staff Bylaws, to the credentials, quality assessment, and peer review files of individual practitioners.

D. Consultants (who may or may not be members of the Medical Staff) charged with the responsibility to review an individual Practitioner or a Department or Section will be allowed access to the Peer Review Records of the Practitioner, Department or Section being reviewed.

E. Vice President of Medical Affairs/Designated Representative: The Board Committees, the Chief Executive Officer, and his designated representatives, shall have access to Peer Review Records to the extent necessary to perform their official functions.

F. Hospital Risk Management/ Performance Improvement Personnel: Shall have access to file information when practice performance is an issue in an asserted claim.

eneral Access by Practitioners to Peer Review Records

A Practitioner will have access to Peer Review Records of other Practitioners only as set out the Paragraph above. A Practitioner will be allowed access to all other information in his/her own Peer Review Record only for the purposes of

(i) discussion of its content with the relevant Department/Section Chiefs and Medical Staff or Hospital Committees, or (ii) in defense of any corrective action which may subject the Practitioner to an Adverse Action or other discipline as described in the Organizational Documents. Use of a Peer Review Record for any other purpose will be a violation of this Policy and will subject the Practitioner to discipline. *Peer review cases/records cannot be copied or removed form Medical Records*.

A member of the medical staff may review minutes of Departments, Sections and Committees that have been approved and signed by the Chair. A release of information form must be signed if any documents are copied for removal from the medical staff office.

ACCESS BY PERSONS OR ORGANIZATIONS OTHER THAN THE HOSPITAL OR PRACTITIONERS

Peer Review at Other Hospitals

A. The Hospital, through the Medical Staff Services Manager, and the Vice President for Medical Affairs, may release information contained in a Peer Review Record, in response to a request from another hospital or its medical staff. The request must include information that the Practitioner is either a member of the requesting hospital's medical staff, exercises privileges at the requesting hospital, or is an applicant for medical staff membership or privileges at that hospital, and must include a release for such records signed by the concerned Practitioner. No information should be released until a copy of a signed authorization, and release from liability has been received which may be in the form of the physician's signature on an application for Medical Staff membership or privileges at the Hospital. Disclosure shall be limited to the specific information requested.

B. If a Practitioner has been the subject of disciplinary action at the Hospital which is required to be reported to the Board of Medical Examiners, or the National Practitioner Data Bank, or has recently challenged a Medical Executive Committee recommendation or action which, if upheld will require a report to such Board, or Data Bank, special care will be taken. All responses to inquiries regarding that Practitioner shall be reviewed and approved by the Chief Executive Officer of the Hospital, the Vice President for Medical Affairs, and the Vice President of Legal Affairs.

Requested by Hospital Surveyors

Hospital surveyors (from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Michigan Department of Licensing and Regulations (MDLR), or the Federal Health Care Financing Administration (HCFA) shall be entitled to inspect records covered by this Policy on Hospital premises in the presence of Hospital or Medical Staff personnel provided that (i) no originals or copies may be removed from the premises and (ii) access is only with the concurrence of the Chief Executive Office of the Hospital (or his designee) and the Vice President for Medical Affairs and (iii) the surveyor demonstrates the following to the Hospital's representatives:

A. Specific statutory or regulatory authority to review the requested materials.

B. That the materials sought are directly relevant to the matter being investigated.

C. That the materials sought are the most direct and least intrusive means to carry out the pending investigation, bearing in mind that Peer Review Records regarding individual Practitioners are considered the most sensitive of materials.

D. Sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff.

Additionally, the Surveyor should be asked to sign the Confidentiality and Notification Statement attached to this Policy as Appendix A and should be given a photocopy of the signed statement. If he/she declines to sign, it should be noted at the bottom of the prepared statement that the surveyor, identified by name, has declined to sign but has been provided a copy of the statement. The annotated statement should then be signed and dated by the Hospital representative and a photocopy should be given to the surveyor. The original will be preserved as a medical staff record.

Subpoenas

All subpoenas or court orders for peer review records shall be referred to the Chief Executive Officer, who will consult with hospital counsel regarding the appropriate response.

Requests for BME, BOE or BDE

Current law allows the Board of Medical Examiners (BME), Board of Osteopathic Examiners (BOE) and the Board of Dental Examiners (BDE) to review certain materials pertaining to Medical Staff hearings concerning adverse recommendations or decisions. Given the current requirements of law, copies of the following records of a Medical Staff disciplinary hearing may be made available to the BME, BOE or BDE, upon specific request of such Board:

A. The notice of charges presented to the practitioner before the beginning of a medical staff hearing.

B. Any document, medical record, or other exhibit received in evidence at that hearing.

C. Any written opinion, finding or conclusions of the Judicial Review Committee in the disciplinary hearing which were made available to the concerned Practitioner.

The Chief Executive Officer of the Hospital, the Vice President for Medical Affairs, and the Vice President of Legal Affairs will review and approve the disclosure before it is made.

her Requests

All other requests by persons or organizations outside the Hospital for information contained in Peer Review Records shall be forwarded to the Chief Executive Officer, of the Hospital. The release of any such information shall

require the concurrence of ...e Medical Executive Committee, the Chief Executive officer of the Hospital, the Vice President for Medical Affairs and the Vice President of Legal Affairs.

The Board may enact disclosure policies applying to requests for other specific entities and, when such disclosed policies are enacted, they shall be appended to this Policy.

Policy	Legal - 43	Document Type: Po
	Deployment	
	Start Date:	03/01/2000
	Approval Date:	07/06/2004

Header Information

Policy Name:	Claims Management - Professional & General Liability	Institution:	Munson Healthcare
Supercedes:		Division:	Munson Healthcare (All)
Level.	Revised	Department:	Legal - 43
Owner(s):	Risk Management	Contributing Departments:	
Priority:		Manual Name:	
Identification Number:	043.G002	Manual Category / Chapter:	
Status:	5. Archived	Restricted to Groups:	
Approval Date:	07/06/2004	Start Date:	03/01/2000
Version Number:	2	Monthly Review Interval:	36
		Review Date:	07/06/2007

Document Body

GUIDELINE:

Munson Healthcare maintains a system for managing professional and general liability claims. The goals of claim management are to control the costs of indemnity and defense and to facilitate reduction of the frequency and severity of claims asserted against MHC facilities and staff.

As described in the Risk Management Program and/or Plan, the vice president of Legal Affairs directs the processes of claim management and is accountable to the chief executive officer and the board of trustees/directors of the MHC entities.

Potentially Compensable Events (PCE) and asserted claims are processed through these claims management guidelines and, when appropriate, the quality improvement/peer review systems.

Refer to the hospital legal proceedings policy for more information on subpoena

service and response, attorney requests for information, search warrants, and depositions.

NOTICE AND CONTROL

The director of Risk Management (RM includes the risk management staff at KMHC, LMHC, & POMH) is responsible for identifying potential claims by maintaining the systems and processes of occurrence reporting, complaint management, and patient rights on behalf of the Office of Legal Affairs and should be promptly notified of events that may lead to a claim. Sources of information include Quality/Safety Monitoring Reports, letters of complaint, reports from medical and hospital staff of unexpected outcomes, Security reports, attorney requests for records, verbal complaints from patients, interaffiliate quality and peer review process, informal referrals from staff, and refusal to settle accounts.

The administrator or vice president of Medical Affairs (VPMA) and vice president of Legal Affairs (VPLA) are notified of potential claims. The VPMA monitors the processes of medical staff peer review and complaint management. The VPLA monitors those cases reported to insurance carriers and those involving legal actions or proceedings.

Notification of claim documentation is completed and filed by RM according to insurance company (MHAIC, CAYMICH, Aetna, others) policy and agreements for claim management. RM reports significant events to the primary carrier immediately by telephone, followed by written notification.

Departments which maintain patient records are notified by RM when a
potential/actual claim is identified and are instructed to implement their process for securing and restricting access to records (Medical Records, Pathology, Radiology, Patient Accounts, Cardiology, Rehab Services, etc.) Records are duplicated or released only upon authorization from RM or the VPLA.

RM has the authority to delay billing a patient's account pending investigation of a PCE or claim and may authorize write-off of portions of an account as necessary to effectively prevent or manage a potential/actual claim. Billing adjustment decisions are coordinated with the VPMA, VPLA, and the director of Patient Accounts. The Corporate Director of Treasury is notified of monetary reserves placed on claims. The director of Internal Audit is apprised of claim reserve status at least annually.

consultants and defense counsel on all issues relevant to claims reported to insurance carriers. The RM is primary liaison with respect to all other PCEs and claims. All insurance company and defense counsel correspondence related to claims is directed to the VPLA. The VPLA relays correspondence to the RM.

The VPLA may elect to file an appearance as defense co-counsel. The VPLA will represent MHC entities at all evaluation and defense strategy meetings with claims consultants and defense counsel.

The VPLA will make periodic reports to the Executive Committee of the MMC Board and, upon request, to the boards of other MHC entities and quality improvement/peer review committees for the purpose of evaluating the Risk Management program and the Claim Management process. The VPLA may delegate this responsibility to the RM as appropriate. See Communication of Claim Information section below.

RESOLUTION

The decision to resolve a claim (authorization for amount to offer or counter-offer as settlement, mediation acceptance or rejection, proceed to trial, etc.) is made by the VPLA in consultation with RM, defense counsel, claims consultant, administrator, president and board committees as deemed appropriate based on the facts and issues of each claim. The VPLA may delegate authority to settle to RM, defense counsel, claims consultant, or administrator within specific parameters agreed upon through consultation.

Consent to settle a claim is given to the insurance company claims consultant by the VPLA. The VPLA may delegate transmission of consent to RM and/or an administrator.

If the VPLA is not available at the time an urgent settlement decision must be made, the claims consultant, defense counsel, RM, and president will confer and make a decision based on previous case review with the VPLA.

The VPLA will represent MHC entities at settlement conferences and trials. The VPLA may delegate representation to RM and/or an administrator, as appropriate.

RM has authority to resolve potentially compensable events of general liability through established protocol and insurance policy

INVESTIGATION

The RM is authorized to conduct an investigation of each potential or asserted claim on behalf of the Office of Legal Affairs.

1. The medical record (and other available records) is reviewed and departments are notified of the need to secure the records. If the medical record is incomplete, a Medical Records Department manager is assigned the responsibility of ensuring prompt completion pursuant to department and Medical Staff policies.

2. The Medical Equipment/Device Reporting policy is implemented if medical equipment or devices are involved.

3. Involved staff are interviewed by RM and/or the primary insurance company claims consultant and/or defense counsel. Notes and summaries of interviews are maintained in the claim file. *Interviews, and signed statements are not given or made (nor requested by managers) without prior approval of RM.*

4. Meetings or interviews with the patient/family are documented and follow up is documented per complaint management policies.

5. All investigation information is filed and labeled as privileged and confidential per quality improvement, peer review and attorney-client privilege requirements. See Claim File Maintenance section below.

The VPLA and RM have access to Medical Staff peer review data and credentialing files for the purpose of investigation and defense of a claim.

1. All policies and methods of protecting the confidentiality of these records will be strictly followed.

2. Defense counsel is allowed review of credentialing files as necessary to defend allegations against an MHC entity.

EVALUATION

The VPLA is the primary liaison with insurance company claims

requirements.

CLAIM FILE MAINTENANCE

The RM creates and maintains the primary file for each potential and asserted professional or general liability claim.

1. Claim files include copies of Notification of Claim forms, all correspondence, all legal proceedings documents, investigation notes and summaries, support documents or exhibits such as photographs, invoices, competency records, policies, etc., and copies of pertinent patient records. Original patient records are maintained in secured files in the originating department as long as the claim is open.

2. Claim files are accessed only by the VPLA, RM, and selected support staff. Files are *Privileged & Confidential*, labeled as such, and are kept in alphabetical order in locked cabinets/offices.

3. Primary and working files are merged when the claim is closed. Files are retained intact for 6 months after the closing date. Files are then reduced to pertinent reference documents (all other contents are purged and confidentially destroyed) and retained for at least 10 years.

RM maintains a computerized database of claims.

1. The database is the working file for periodic review and updates of the status of the claim, as well as data retrieval for individual and aggregate reports. All database forms and reports are *Privileged & Confidential* and are labeled as such. A copy of the completed Claim Status form is retained in the claim file when the case is closed.

2. Access to this database is restricted to the VPLA, RM, and the database support staff. Affiliate facility risk managers and administrators have access to data relating to claims against their facility.

Claim files and the database contain information that is protected from discovery under the Michigan statutes for quality improvement and peer review and/or as attorney work product. As such, the information is not released without prior approval of the VPLA and

generally cannot be released except by court order:

1 Physician peer review data is not retained in a claim file.

2. Original Quality/Safety Monitoring Reports and other quality improvement process documentation are not retained in a claim file. Copies of Quality/Safety Monitoring Reports are made and released to the insurance company and/or defense counsel only on written request and as attorney-client privilege allows.

COMMUNICATION OF CLAIM DATA

All potential and asserted claims are analyzed by the RM for risk management and quality improvement opportunities.

1. Individual staff, departments, administrators, and medical staff services/sections are notified of identified issues via established quality improvement or peer review systems.

2. RM staff serve as consultants to the quality improvement and peer review committees of MHC entities on development, implementation, and evaluation of processes to prevent similar issues and outcomes.

Claim data is reported to Safety Committees, board or board subcommittees, Medical Staff peer review committees, and other committees charged with peer review functions, as required in their purpose/function statements or goals/objectives.

1. Claim data is reported in aggregate format without identifying names of plaintiff or defendants, or discussion of defense strategy. The focus is on efficient and effective management of costs and on quality improvement opportunities.

2. All distributed information is *Privileged and Confidential*, is labeled as such, and is not retained by individual committee members.

- Compliance Monitoring
- Process Cycle Information
- Logs

EXHIBIT 6

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GRAND TRAVERSE

JEANNE HARRISON,

Plaintiff,

v

File No. 09-27611-NH
HON. PHILIP E. RODGERS, JR.

MUNSON HEALTHCARE, INC., a Michigan corporation; SURGICAL ASSOCIATES OF TRAVERSE CITY, PLCC; and WILLIAM POTTHOFF, M.D.,

Defendants.
/

Thomas C. Miller (P17786)
Attorney for Plaintiff

Thomas R. Hall (P42350)
Attorney for Defendant Munson Healthcare

Brett J. Bean (P31152)
Attorney for Defendants Potthoff and Surgical Associates

DECISION AND ORDER
REGARDING MOTION FOR SANCTIONS

The trial was commenced in the above-captioned action on January 12, 2011. The cause of action was based upon a burn received by the Plaintiff outside the surgical field during a thyroidectomy. The cautery device known as a Bovie penetrated the drape, contacted the Plaintiff's arm and burned her. The burn was discovered and repaired at the conclusion of the surgery.

Plaintiff aggressively pursued the cause of this burn with pre-trial discovery. The Defendants claimed they did not know how the Bovie came to penetrate the drape and cause injury to the Plaintiff's left arm. Near the conclusion of the discovery period two individuals present in the surgical suite testified that they heard the alarm indicating the Bovie had been activated and saw that it was not in the Defendant Physician's hand. When the Defendant Physician stepped away from the Plaintiff, the Bovie was between his body and the Plaintiff's

left arm and was activated by pressure exerted by him leaning up against the Plaintiff. These witnesses did not recall how the Bovie came to be unholstered and located between the Defendant Physician and Plaintiff.

The parties agreed that the standard of care required the Bovie to be holstered when it was not in use. Given the absence of recollection as to how the Bovie came to penetrate the drape, the defense theory was based on habit and practice and probable mechanisms by which the Bovie may have been inadvertently unholstered during the surgical process without violating the standard of care.

On the third day of the trial, during the in-limine examination of the Defendant Hospital's Operating Room Manager, Barbara Peterson, it was first revealed that a contemporary incident report had been prepared. See, Exhibit A. The Court required that the report and any related documents be produced for an in-camera inspection. See, Exhibits A through D. Several points became immediately apparent upon inspecting the documents.

First and most importantly, the incident report reached a factual conclusion as to how the Bovie had come to penetrate the drape. Second, the Defendants claimed a peer review privilege and it was evident that the issues associated with peer review could not be resolved during the course of the jury trial.[1] Third, if the facts associated with the described incident were provided to the Plaintiff, the jury, and the Court, the Court would not allow expert testimony based on habit and practice regarding how the Bovie may have become unholstered which theories were inconsistent with the factual findings of the contemporaneous internal investigation.

The Court on its own motion declared a mistrial. A full-day evidentiary hearing was set to determine whether these documents were protected in whole or in part by the peer review statute; whether the facts contained within them were subject to production as opposed to the conclusions regarding standard of care issues, discipline or subsequent remedial measures; and whether a defense could be presented that was inconsistent with the contemporaneous investigation described by peer review documents and, if so, how that could be accomplished ethically.

The hearing was concluded on March 1, 2011 and substantial testimony was received. The issues were also fully briefed by the parties and the Court took the matter under advisement

[1] A key witness was unavailable due to a family emergency.

to review the proffered authority and documents.[2] The Court will now provide its conclusions of law on undisputed facts.

The Michigan Public Health Code provides rules for maintaining patient records and for confidentiality. MCL 333.20175. Most relevant to this discussion is the confidentiality provision commonly referred to as the peer review privilege, which is found in Section 8 and provides as follows:

> The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena. MCL 333.20175(8).

The Defendants take the position that even the factual information collected during the peer review process is absolutely protected from disclosure. Recognizing that peer review serves an important public purpose, it is still appropriate to inquire whether the Defendant Hospital can protect facts, as opposed to conclusions, from disclosure and, if so, whether it legally and ethically can take positions in litigation which are inconsistent with those facts. First, the Court must determine whether the incident report and related investigative documents were the product of "individuals or committees assigned a professional review function in a health facility." *Id.*

The manner by which a trial court determines whether documents are protected by the peer review privilege is described in a number of Michigan appellate decisions. The trial court is instructed to consider the hospital's by-laws, internal rules and regulations, and whether the committee overseeing the creation of the documents is involved in retrospective analysis for improvement or part of current patient care. *In re Lieberman*, 250 Mich App 381, 385; 646 NW2d 199 (2002); *Dorris v Detroit Osteopathic Hosp*, 460 Mich 26, 42; and *Monty v Warren Hosp Corp*, 422 Mich 138, 147; 336 NW2d 198 (1985).

At the evidentiary hearing, the Defendant Hospital's peer review procedures were described by various witnesses. Paul Shirilla, Vice President and General Counsel for the Defendant Hospital, testified regarding the peer review process, the quality committee and oversight by the Defendant Hospital's Board of Directors. Mr. Shirilla was not involved in the

[2] Relevant documents included the Defendant Hospital's Bylaws (Exhibit 1), its Risk Management Occurrence Reporting Policy (Exhibit 6), Confidentiality of Peer Review Records (Exhibit 8), the Incident Report (Exhibit A) and the related investigative and follow up materials (Exhibits B, C and D).

preparation or review of discovery responses in this case but did testify that an occurrence or incident report is part of the peer review process. However, he also acknowledged that incident reports and Risk Manager investigations are not discussed in the Defendant Hospital's policy on Confidentiality of Peer Review Records. (Exhibit 8.)

David McGreaham, M.D., is the Defendant Hospital's Director of Medicine. Dr. McGreaham also testified regarding peer review or quality assurance at the Defendant Hospital. He, too, opined that incident reports such as the one generated in this case are part of the peer review process. The Court agrees, but the inquiry cannot end here.

Dr. McGreaham acknowledged that the Hospital has an internal policy that precludes the incident report from inclusion in the medical chart, but the facts of the event are required to be charted. See, Exhibit 6. Interestingly, Dr. McGreaham testified that the Defendant Hospital has not developed forms to do so and, in his opinion, as little as possible should be disclosed to the patient in the medical record regarding the facts of an unusual event.

Exhibit 6 at page 2 states as follows:

> 4. Document the *facts of the event* in the patient's medical record using forms and documentation procedures as would be done for any other problem or deviation from normal or expected parameters.
>
> a. Include date, time, *facts of event*, and care rendered . . .

And, at page 3, the Exhibit 6 states:

> The medical record should contain only *facts of the event.* Never document that an occurrence report has been completed nor refer to such report in the patient's chart. (Emphasis supplied.)

The Defendant Hospital's Risk Manager, Bonnie Schreiber, also admitted there were no "forms and documentation procedures" to implement this Hospital policy. To her credit, Ms. Schreiber stated her belief that relevant facts should not be withheld from the patient.[3] Ms. Schreiber oversees the peer review process and is responsible for maintaining the occurrence or incident reports. It was Ms. Schreiber who drafted Exhibit 6 and who caused Barbara Peterson to conduct an investigation and it was Ms. Schreiber who accepted the findings of Ms. Peterson

[3] Ms. Schreiber's opinion was supported by Mary Murphy, Director of Surgical Services (Retired), who testified that she expected staff to write down the facts of an untoward event.

without comment or concern.[4] It was also Ms. Schreiber who was responsible for reviewing the Defendant Hospital's sworn discovery responses, including interrogatory answers, with counsel prior to their submission to the Plaintiff.

When the Hospital was asked to explain how the Bovie came to burn a hole in the drape, the Hospital's consistent response was "unknown" or "may not ever be known" and explanations were then based on habit and custom. See, e.g., Defendant Hospital's Answers to Plaintiff's Requests to Admit Dated December 14, 2009, Defendant Hospital's Answers to Plaintiff's Third Interrogatories Dated April 7, 2010. Two members of the surgical team recalled the Bovie alarm being activated, that it was not in the Defendant Physician's hand, and that as he stepped away from the patient it was discovered between him and the Patient's body.

No individual has a present memory of how the Bovie came to be on the drape, unholstered and in a position to burn the patient. Since the standard of care requires the Bovie to be holstered, it was critical in this case to know whether it was improperly placed on the drape out of its holster and not promptly reholstered by a member of the surgical team, or whether it became accidentally unholstered in a way that was within the standard of care.

On this point, the Defendant Hospital stated that the event was "sudden, accidental and unpreventable" . . . . and "more than likely resulted from an inadvertent dislodging of the Bovie from its holster." According to the Hospital, "As all Defendants have maintained throughout, what happened to this patient was entirely inadvertent, and could not reasonably have been detected and/or prevented before it occurred." See, Exhibits 17 and 20 to Plaintiff's Motion for Imposition of Sanctions.

The conclusion of the internal investigation was diametrically opposed to the Defendant Hospital's statements. In fact, the Bovie had not become accidentally unholstered: "Bovie was laid on the drape," and the "Bovie holder was on field for this case, however, Bovie was not placed in it." See, Exhibit A. These facts were not charted. Whether or not laying the Bovie on the drape was determined by the Defendant Hospital to be a standard of care violation, a cause for discipline or grounds for the implementation of subsequent remedial measures are not facts

[4] This action was consistent with the procedure described in the Risk Management Policy, Exhibit 6 at page 3. Mary Murphy, then Director of Surgical Services, testified that she too would have reviewed Ms. Peterson's findings and had them corrected if necessary.

sought by the Plaintiff nor would they be discoverable. Clearly, such internal conclusions drawn as part of the peer review process are protected from discovery for sound policy reasons.

In determining whether facts should be disclosed as opposed to deliberations, conclusions or subsequent remedial measures, the discussion in *Centennial Healthcare Mgt Corp v Michigan Dep't of Consumer & Industry Services*, 254 Mich App 275; 657 NW2d 746 (2002) is helpful. In discussing the scope of the peer review privilege, the *Centennial* court wrote as follows:

> Certainly, in the abstract, the peer review committee cannot properly review performance in a facility without hard facts at its disposal. However, *it is not the facts themselves that are at the heart of the peer review process. Rather, it is what is done with those facts that is essential to the internal review process*, i.e., a candid assessment of what those facts indicate, and the best way to improve the situation represented by those facts. Simply put, the logic of the principle of confidentiality in the peer review context does not require construing the limits of the privilege to cover any and all factual material that is assembled at that the direction of the peer review committee . . . *It is not the existence of the facts of an incident or accident that must be kept confidential in order for the committee to effectuate its purpose; it is how the committee discusses, deliberates, evaluates and judges those facts that the privilege is designed to protect. Id.* at pp 290, 291. (Emphasis supplied.)

The sound public policy reasons that support the nondisclosure of protected internal investigations, then, is not so broad as to allow the Defendant Hospital to ignore those facts and pretend they do not exist. Indeed, the Hospital's internal policy, fairly interpreted, requires that the facts of an untoward incident be charted.[5] Clearly, the standard of care conclusions,

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[5] The argument against disclosing facts as opposed to conclusions is that medical staff will not be forthcoming in occurrence or peer review investigations. This argument is unprofessional and unpersuasive. The mission of medical staff and their careers is patient care, not covering up the occasional mistake. Footnote 11 in the *Centennial* opinion is instructive on this point. It reads as follows:

> We note that authority exists that rejects the premise that the function of a peer review committee would be impaired if such a privilege did not exist. See, e.g., *Syposs v United States*, 63 F Supp 2d 301, 306 (WD NY, 1999). Indeed, the Michigan Supreme Court appears to be heading away from the validity of this presumption. In *Bradley v Saranac Community Schools Bd of Ed*, 455 Mich 285, 299-300; 565 NW2d 650 (1997), the Court observed:
>
> > The plaintiffs assert that the integrity of the evaluation process will be compromised by the disclosure of their personnel records. They suggest that the evaluators will be less inclined to candidly evaluate their employees if the evaluations are to be made public. We draw the opposite conclusion. Making such documents publicly available seems more likely to foster candid, accurate, and conscientious evaluations than suppressing them because the person performing the evaluations will be aware that the documents being prepared may be disclosed to the public, thus subjecting the evaluator, as well as the employee being evaluated, to public scrutiny. *Id.* at p 289.

disciplinary action or subsequent remedial measures that may be flow from an untoward event need not and should not be charted. As the *Centennial* Court noted, "it is not the facts of an incident that must be kept confidential . . . it is how the committee discusses, deliberates, evaluates and judges those facts that the privilege is designed to protect." *Id.* at p 291.

The finding that the Bovie was laid on the drape and not placed in the holster is grossly inconsistent with an argument that the Bovie was properly holstered and then accidentally unholstered. This contemporaneous factual finding was recorded by Barbara Peterson, the only individual who conducted an investigation. No one else has any present memory as to how an unholstered Bovie came to be on the drape. Further, unlike the incident report in *Vergote v K-Mart Corp* (after remand), 158 Mich App 96, 109; 404 NW2d 711 (1987), the factual conclusion in the incident report is of dispositive significance and was not elicited from other sources during the trial. The report was not given to the jury and it would appear that it would be error to do so.

However, the facts recorded in the report as opposed to the conclusions drawn in the report should not have been kept from the jury in view of the holding in *Centennial* and the Defendant Hospital's own internal policy. See, Exhibit 6. Those facts should have been recorded in the medical chart. And, if the facts are not recorded and not given to the jury, the Defendants are precluded ethically from offering an explanation that is inconsistent with those facts.[6] This is true whether or not the incident report was requested.[7]

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[6] MRPC 3.3 provides in relevant part as follows:

> (a) A lawyer shall not knowingly:
>
> (1) make a false statement of material fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;
>
> . . .
>
> (3) offer evidence that the lawyer knows to be false. If a lawyer has offered material evidence and comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal
>
> (d) In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts that are known to the lawyer and that will enable the tribunal to make an informed decision, whether or not the facts are adverse.
>
> (e) When false evidence is offered, a conflict may arise between the lawyer's duty to keep the client's revelations confidential and the duty of candor to the court. Upon ascertaining that material evidence is false, the lawyer should seek to persuade the client that the evidence should not be offered or, if it has been offered, that its false character should immediately be disclosed. If the persuasion is ineffective, the lawyer must take reasonable remedial measures. The advocate

The notes to the Michigan Rules of Professional Conduct 3.3 recognize that, "As officers of the court, lawyers have special duties to avoid conduct that undermines the integrity of the adjudicative process . . . the lawyer must not allow the tribunal to be mislead by false statements of law or fact or evidence that the lawyer knows to be false." The comments go on to note that "[t]here are circumstances where failure to make a disclosure is the equivalent of an affirmative misrepresentation . . . [and], (a)(3) requires that a lawyer refuse to offer evidence that the lawyer knows to be false, regardless of the client's wishes."

Even a casual inspection of MRPC 3.3 should prevent a lawyer from offering a defense to the court that is inconsistent with known but undisclosed facts. When the Defendant Hospital stated that it is unknown how the Bovie came to be on the drape in an unholstered position, it was not being candid. The incident report concluded that the Bovie was "laid on the drape." The incident report concluded that the "Bovie holster was on the field for this case, however, Bovie was not placed in it." Representations to the contrary, suggestions that it was accidentally unholstered or the failure to make a full factual disclosure are all affirmative misrepresentations and violations of the Michigan Rules of Professional Conduct. MRPC 3.3.

Given that the patient was unconscious during the relevant time period, the Plaintiff brought her complaint as a simple negligence action on a *res ipsa loquitur* theory. The Court dismissed the complaint on the Defendants' Motion for Summary Disposition because it found that standard of care testimony was required to determine whether the burn could have occurred in the absence of negligence. In fact, the alternative theory proposed by the Defendants could explain a burn occurring in the absence of negligence. Unfortunately for the Defendants, the alternative theory is not consistent with the facts recorded in the incident report.

Contrary to the Michigan Rules of Professional Conduct, the Defendant Hospital caused its attorney to move to dismiss the *res ipsa loquitur* theory with the argument that standard of care testimony was required. Yet, knowing the unholstered Bovie was laid on the drape, a standard of care violation should have been admitted. If counsel for the Defendants did not know this argument was false, the Defendant Hospital either did not disclose the incident report

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should seek to withdraw if that will remedy the situation. If withdrawal from the representation is not permitted or will not remedy the effect of the false evidence, the lawyer must make such disclosure to the tribunal as is reasonably necessary to remedy the situation, even if doing so requires the lawyer to reveal information that otherwise would be protected by Rule 1.6.

[7] Bonnie Schreiber testified that the incident report was requested by Plaintiff's counsel on November 25, 2008.

to him or, contrary to MRPC 3.1, he failed "to inform [himself] about the facts of [his] client's case . . . . [so he could] make good-faith arguments in support of [the] client's position." Defendant Hospital's recent decision to admit liability is finally consistent with facts long known to Defendant Hospital. The fact that the unholstered Bovie was laid on the drape and was not inadvertently unholstered was known to the Defendant Hospital throughout this litigation and was known by its attorney at some point prior to the trial.[8]

This Court accepted the Defendants' argument and dismissed the *res ipsa loquitur* theory and ordered the case to be refiled as a medical negligence action with an affidavit of merit. Had the fact that the Bovie was laid on the drape been disclosed from the onset, this case would have been tried without delay based on admitted liability. Substantial time and energy was wasted in the effort to learn how the Bovie came to penetrate the drape and burn the Plaintiff's arm. Standard of care experts were retained and deposed. Facilitative mediation was conducted, a final settlement conference completed and the case was tried to a jury for three days.

If the Exhibit A incident report is a protected peer review document, and the Court finds that it is, the facts regarding causation had to be disclosed, liability admitted or a defense presented that was consistent with the internal investigation. Again, it is not as though the incident report is inconsistent with some other witnesses' present recollection of these same events.[9] The public policy supporting the investigation of untoward events and the retrospective review of causation for purposes of improving medical care is not furthered by failing to disclose those facts, covering up negligence and presenting an inappropriate defense. The Hospital's Risk Manager and defense counsel participated in a course of defense which, in this Court's opinion, is materially inconsistent with the findings of the contemporaneous investigation documented in the Exhibit A incident report and violated MRPC 3.3(a)(1), (3) and (e). Such a defense must be precluded as a matter of law. Their actions have prejudiced the Plaintiff in both delay and expense and Plaintiff has filed a Motion for Sanctions.

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[8] The Defendant Physician was never consulted in the internal peer review investigation, had no memory of the incident, and the incident report was never shared with him until it was disclosed to the Court. His separate counsel did not appear until after the mistrial was declared.

[9] Every person who was in the surgical suite for any period of time has now testified to their memory or lack thereof under oath.

The Court has reviewed the Plaintiff's Motion for Sanctions, the Defendants' response and the Plaintiff's reply. The Court dispenses with further oral argument. MCR 2.119(E)(3). The operative court rule is MCR 2.114, which provides in relevant part:

> (C) Signature.
>
> > (1) *Requirement.* Every document of a party represented by an attorney shall be signed by at least one attorney of record . . .
>
> (D) Effect of Signature. The signature of an attorney or party, . . . constitutes a certification by the signer that . . .
>
> > (2) to the best of his or her knowledge, information and belief formed after reasonable inquiry, the document is well grounded in fact and is warranted by existing law or a good-faith argument for the extension, modification, or reversal of existing law; and
>
> (E) Sanctions for Violation. If a document is signed in violation of this rule, the court, on the motion of a party or on its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the document, including reasonable attorney fees. The court may not assess punitive damages.

Commencing with the Motion for Summary Disposition of the Plaintiff's original complaint, the Defendant Hospital initiated a course of defense that was based on the standard of care being a material factual issue. The Defendant Hospital persisted in this defense throughout this litigation when it was refiled as a medical negligence action insisting that there was no standard of care violation. At all relevant times, the Defendant Hospital knew that the unholstered Bovie had been laid on the drape and that whether it was laid there by the Physician or a member of the surgical team, the standard of care required a member of the surgical team to immediately reholster it. This was not done and the Plaintiff was burned. The standard of care was violated and the defense was inconsistent with the known undisputed facts.

The incident report was the product of the Defendant Hospital's Risk Management Policy. The investigation was conducted by the Operating Room Manager, reviewed by the Director of Surgical Services and the Defendant Hospital's Risk Manager. No corrections, additions or deletions were made. In the absence of contemporary witness memory, it is an irrefutable statement of how the Bovie came to injure the Plaintiff. The Hospital's defense was

never well grounded in fact, and the pleadings, discovery responses, motions and briefs filed in this case were signed in contravention of MCR 2.114(D)(2). Sanctions will be assessed.

The Defendants' objections to an award of sanctions are predicated on the argument that the incident report is protected by the peer review privilege and need not be disclosed. What the Defendant Hospital fails to appreciate is that the peer review privilege protects the Hospital's conclusions, discipline and subsequent remedial measures.[10] The Court has not found a case that would allow the Defendant Hospital to fail to disclose the causation facts and present a defense inconsistent with them.

The objection that the costs and fees sought by the Plaintiff are not authorized by statute is also incorrect. The relevant court rule is MCR 2.114 and its companion statute is MCL 600.2591. The appropriate sanction includes all reasonable expenses and reasonable attorney fees incurred as a result of the Defendant Hospital's discovery violations. MCL 600.2591(2) and MCR 2.114(E).

Plaintiff's Motion for Sanctions as amended seeks costs in the amount of $2,658.69 (Plaintiff's Exhibit 22), and fees at the rate of $200 an hour for 254 hours. (Plaintiff Exhibit 23.) The Defendants' objection to the costs are not that they were not incurred but that they are not authorized by statute. For reasons previously discussed, the Court rejects this argument. The costs were incurred and are reasonable.

The Defendants do not object to the $200 hourly rate sought by the Plaintiff's counsel. It is substantially less than the $400 per hour median rate for attorneys, such as Plaintiff's counsel, who specialize in plaintiff's medical malpractice work.[11] See, "Economics of Law Practice in Michigan." *Michigan Bar Journal*, February 2011, p 20. The rate of $200 per hour is identical with the median rate for attorneys practicing in Grand Traverse County, *Id.*, p 21 and in the 13th Circuit Court, *Id.*, p 23.

Finally, the Defendants do not dispute that the hours claimed by Plaintiff's counsel were actually incurred. Rather, the Defendant Hospital objects to the inclusion of hours for travel.

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[10] It is a long-established maxim that privileges "ought to be strictly confined within the narrowest possible limits consistent with logic of its principle." *Centennial, Id.* at p 288, citing 8 Wigmore, Evidence (McNaughton rev), § 2291, p 554.

[11] Recognizing the factors articulated in *Crawley v Schick*, 48 Mich App 728, 737; 211 NW2d 217 (1973), Plaintiff's attorney is experienced, limits his practice to medical negligence cases and is a well-respected member of the Bar. He prepared his case, pursued discovery, diligently filed and responded to motions, took depositions, tried the case for three days and successfully prepared this Motion for Sanctions. His fees are reasonable.

Both counsel traveled to this Court from down state and both counsel maintain statewide law practices. The medical negligence field is highly complex and is a specialized form of practice where attorneys on both sides of the bar conduct statewide practices. The Court sees no reason in common sense or sound public policy to exclude those hours associated with travel from the attorney's fees unnecessarily and wrongfully incurred due to the Defendant Hospital's discovery abuses.

Finally, the Defendant Hospital objects to an award of $450 for Plaintiff's time and travel costs. (Plaintiff Exhibit 24.) Having burned her, failed to tell her why, taken her through facilitative mediation, a final settlement conference, a three-day trial and only now admitting liability, one cannot be shocked but only disappointed at this objection to modest travel costs and compensation for her wasted time.

For all the foregoing reasons, the Court will assess costs including Plaintiff's travel costs ($150) in the amount $2,808.69, attorney fees in the amount of $50,800 and $350 for Plaintiff's time for a total sanctions award of $53,958.69. These sanctions shall be paid jointly and severally by the Defendant Hospital and its attorneys to Plaintiff and her attorney not less than 28 days from the date signed below.

The Circuit Court Administration Office shall provide the parties with notice of the date for a new trial which shall proceed upon the Defendant Hospital's admitted liability.

This order does not resolve the last issue pending in this case and does not close the file.

IT IS SO ORDERED.

HONORABLE PHILIP E. RODGERS, JR.
Circuit Court Judge

Dated: 4/08/11

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GRAND TRAVERSE

JEANNE HARRISON,

Plaintiff,

v

File No. 09-27611-NH
HON. PHILIP E. RODGERS, JR.

MUNSON HEALTHCARE, INC., a Michigan corporation; SURGICAL ASSOCIATES OF TRAVERSE CITY, PLCC; and WILLIAM POTTHOFF, M.D.,

Defendants.
/

Thomas C. Miller (P17786)
Attorney for Plaintiff

Thomas R. Hall (P42350)
Attorney for Defendant Munson Healthcare

Graham K. Crabtree (P31590)
Attorney for Defendant Munson Healthcare

Brett J. Bean (P31152)
Attorney for Defendants Potthoff and Surgical Associates

DECISION AND ORDER
DENYING MOTION FOR RECONSIDERATION

The Defendant Munson Healthcare, Inc., filed a Motion for Reconsideration of Decision and Order Regarding Motion for Sanctions. The motion was timely filed in accordance with MCR 2.119(F)(1). No response is necessary and the Court does not require oral arguments. The Court is denying the Motion for Reconsideration because it merely presents the same issues previously ruled upon by the Court. No palpable error has been shown by which the Court was mislead nor is the Court persuaded that a different disposition of the motion must result from correction of any ostensible error.

To the contrary, the Defendant's argument only amplifies the reasoning which underlies the Court's earlier decision. Several points, however, should be highlighted. First, the Court did not order that the Incident Report be disclosed but rather that the facts contained within it were required to be disclosed.

Second, internal hospital policy requires these facts to be disclosed.[1] The holding in *Centennial Healthcare Mgmt Corp v Dep't of Consumer and Industry Service*, 254 Mich App 275, 290-291; 657 NW2d 746 (2002), clearly distinguishes between facts which are not subject to peer review protection and the conclusions, deliberations and subsequent remedial measures which are properly protected.

Third, the Defendant Hospital argues that the facts in the Incident Report should not be disclosed. This would countenance the presentation of a "habit and practice" defense in this case. The Court respectfully reminds the Defendant Hospital and its counsel that it is the clear and unambiguous language of the factual statements found in the Incident Report which ethically preclude any defense based upon habit and practice. In the context of contract interpretation, Michigan's Appellate Courts have long recognized that disagreements between parties do not create an ambiguity where there is none.[2] *Harbor Park Market Inc v Gronda*, 277 Mich App 126, 133; 743 NW2d 585 (2007); *Gortney v Norfolk & WR Co*, 216 Mich App 535, 540; 549 NW2d 612 (1996).

Finally, the submission of additional affidavits from two witnesses who testified at the evidentiary hearing is highly irregular. No witness has any present recollection of what occurred at the time of the surgery nor does Ms. Peterson have any present recollection of her investigation other than that she conducted one and it is reflected in her Incident Report. Given that all parties were represented by counsel at the evidentiary hearing, the submission of post-hearing affidavits not subject to cross examination regarding what these witnesses "intended" is inappropriate, self-serving and, in view of the testimony the Court received, of no substantive value.

The parties may wish to argue about the law and the weight of the *Centennial* opinion with the Court of Appeals, but the Hospital's internal policies are crystal clear. The facts were

[1] See, Risk Management Occurrence Reporting Policy, (Exhibit 6).

[2] Perhaps the Defendant Hospital should be reminded that it suggested to the Plaintiff that she was burned because the Bovie alarm needed to be louder, a fact that was not true. The alarm was clearly heard and caused the Bovie to be discovered between the Defendant Doctor and the Plaintiff.

required to be recorded in the medical chart and they were not. Worse, Plaintiff was misled into believing a low volume alarm was the cause of her injury and not the failure to holster the Bovie.

Accepting as vigorous advocacy defense counsel's representation that a habit and practice defense was ethical, the Defendant Hospital would apparently have this defense presented without the Incident Report facts being charted or otherwise divulged, with false information regarding an alarm and without any cross examination on the Incident Report facts. The lack of ethics embodied in this argument is appalling.[3] The claim of ambiguity ascribed to the Incident Report is shallow and does not even rise to the level of sophistry. The motion for reconsideration is denied.

IT IS SO ORDERED.

HONORABLE PHILIP E. RODGERS, JR.
Circuit Court Judge

Dated: 5/04/11

[3] We recognize that the attorney client privilege draws "a dark cloak over the truth" and therefore forbid an attorney's presentation of false evidence in Court. The peer review privilege is hardly of the same time-honored stature. Yet, the Defendant Hospital would ignore its own internal policy to report the facts of an unusual event, mislead the patient as to the actual cause, pursue a defense which is grossly inconsistent with the only facts contemporaneously reported and avoid any cross examination on that gross inconsistency. To suggest this is just and ethical in the promotion of sound medical practices is insulting to patients, denigrates the ethics of our profession and casts shame on those who argue the position.

EXHIBIT 7

sanctions made that was reviewed by the Court and subject to the Court's order imposing sanctions, those are opposed by the defendants.

To review where we are. There are a couple of, I think, important points that need to be addressed, the first deals with sanctions of, if any, following the Court's order.

This Court believes, absent instruction to the contrary, that any award of sanctions for the time and energy put into the appeal should this Court be affirmed is a decision that lies with the Court of Appeals. I certainly can understand how the defendants can make a nonfrivolous argument, in light of the statute, that they wish to see a change in the law with respect to say a centennial opinion. With respect to the hospital's own internal policy that would require the facts of an untoward event to be disclosed and whether sanction should continue to be awarded, again, seems to this Judge to be an issue to be determined by the Court of Appeals.

Perhaps the most troublesome part of this case is the ethical issues, and I've made that clear to counsel on both sides from the moment they first appeared to this Court. Perhaps I am a dinosaur, and perhaps as I swear in new attorneys two different

times of the year and I ask them to read the oath into the record so they understand the promises they are making to the state, to fellow lawyers, to clients, perhaps that's all a wasted effort, maybe it doesn't matter anymore. But, the notion that one could protect the facts of an untoward event and then present a defense that in this Judge's view is diametrically opposed to them and not have any problem is so repugnant to this Court's sense of justice. I am at a loss how repulsed I am by that argument, how it denigrates our profession. You know, I been here, this is my 21st year on the bench, I was licensed in 1978, I was always trained by the people who mentored me, lawyers, partners, judges, that every problem is solvable as long as we're honest about the facts. I haven't sentenced many people for perjury over the years, but I've sent them all to prison, it goes to the fundamental core of what we do.

I can't imagine on the facts of this case, a good faith argument to present a habit acknowledged practice defense about how a Bovie could become accidentally unholsterd when the only evidence is it was never put in the holster in the first place, the only evidence. No one has a contrary memory, no one says I was there I know what happened, that incident

report is totally wrong, no one is saying that. But, we would have conducted a trial and asked a jury to look at this hypothetical testimony and no one ever would have known that at the time the Bovie was placed on the field the Bovie was on the field and the Bovie was never passed. We have this trial and there is no cross-examination of what I can charitably characterize as a strained argument by the defendants. That is unjust, it is inappropriate and it denigrates the ethics of our profession, which absolutely precludes lawyers from knowingly presenting a false defense. Perhaps we don't live in a world of spin, and black is white and white is black and the sun comes up at night and the moon comes up in the day, we can argue that. As long as we can make the argument and not be humiliated and embarrassed as we stand there in front of a judge or a group of Court of Appeals judges, then I guess it's okay to say what we want to say. To see this modest burn case, no offense, the medical malpractice cases I've defended and presided over over the years deal with death, birth trauma, people who become paralyzed and can't walk out of the hospital, to see this modest defense here potentially rise to the level of sanctions. The egregious ethical behavior here is stunning to me,

absolutely stunning. But, that's a decision ultimately for the Court of Appeals, and I will be instructed if so, I will not be persuaded. And, if things have changed to that degree, if it is so important to the quality of healthcare in this state that we would allow a defense like this to be presented and there never be any cross-examination, we're going to ignore Munson's own internal policy, we're not going to require these facts to be charted, disclosed, reviewed or cross-examined we will knowingly present false defenses to the jury because we can spin them, that is a world I don't know. Does that mean sanctions are automatic on appeal, I don't think so, I think that's a determination to be made by the Court of Appeals.

Should there be supplemental sanctions here, I understand the plaintiff's argument that the Court's opinion goes back to the official filing. And, clearly, this Court's finding, having reviewed the facts, are that -- not that the case would have gone forward as an ordinary negligence case, the case would have gone forward as a trial on damages. Liability should have been admitted from the get go, there was never a good faith argument presented here. The Court indicated it would entertain a motion for sanctions.

EXHIBIT 8

MUNSON MEDICAL CENTER

373-52-2561

June 5, 2007

Mrs. Jeanne Harrison
3589 Hunters Rd.
Luzerne, Michigan 48636

Dear Mrs. Harrison,

I am writing to follow up with you in regard to the burn incident that occurred during your surgical procedure on April 24, 2007. It is our goal to review such incidents in an effort to gain understanding of why they occurred and how we can prevent future occurrences.

This case has been confidentially reviewed and the following initiatives have been reinforced: The mandatory and active use of cautery protective devices anytime cautery is used. In addition, we have mandated the use of an alarm that is audible every time the device is activated. These precautions will decrease the likelihood of a burn event reoccurring. We will continue to measure these practices to ensure 100% compliance.

If you have questions or would like to discuss this matter further, please feel free to contact Tim Lueck in Patient Relations at 935-5051.

Sincerely,

Barbara A. Peterson

Barbara A. Peterson, CNOR, BS
Operating Room Manager

cc: Dr. William Potthoff
Tim Lueck, Patient Relations

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EXHIBIT
P-L

EXHIBIT 9

Administrative Manual
INCIDENT AND IMPROVEMENT REPORTING

Policy Number: 6.06

Objective: To report all incidents and opportunities for improvement within Covenant HealthCare System. These reports will be tracked and trended for the purposes of developing safety prevention, loss control and peer review programs which will benefit all patients and users of Covenant HealthCare System's facilities and services.

Scope: All employees of Covenant HealthCare System.

Policy: Covenant HealthCare System recognizes the importance of accurately reporting all adverse incidents occurring at Covenant HealthCare Facilities. Information about the incident will be completely documented on the approved Improvement Report Form (see attached, Form #PF00347 Improvement Reports, #PF01916 OB Services, PF02034 Fall Report). This reporting process is designed to assure prompt, thorough and appropriate analysis and evaluation of the events and circumstances that may have contributed to the occurrence. In addition, identification of potential "Sentinel Events" and initiating the procedures detailed in Administrative Policy – Sentinel Event Reporting and Investigation is important.

Definitions:

Incident – any occurrence or event not consistent with the normal, or routine operation in this healthcare facility. The potential for injury and or property damage exists. The event may involve patients, visitors or medical staff. Examples include, but are not limited to:

- Medication errors
- Slips and falls
- Equipment failures
- Theft, vandalism, unauthorized solicitation
- Hazardous exposures to chemical, toxic or biohazards substances
- Incidents reported to a medical examiner, policy agency, HCFA, county or state health departments, the FDA or the Michigan Department of Commerce
- Any adverse events that may become public knowledge or communicated to the media.

Sentinel Event – Unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness. Examples of sentinel events include but are not limited to the following:

- Suicide of a patient
- Infant abduction or discharge to wrong family
- Confirmed rape of a patient on premises
- Hemolytic Transfusion Reaction
- Surgery on the wrong body part

Procedures: Reporting Process

1. The employee or medical staff involved in, observing, or discovering the incident is responsible for initiating and completing the appropriate sections of the Improvement Report Form. If necessary the supervisor will assist in the completion of the report. Completed forms are to be turned into the department manager immediately.
   - The information documented in the Improvement Report Form or collected during the investigation of the incident is protected by Michigan Peer Review Statutes. Care must be taken by all parties involved as to not destroy this protection.
   - Comments about the incident should not be discussed in public areas, in front of the patient, visitors or other third parties.
   - The documentation in the medical record should only reflect the facts and treatment rendered, not that an Improvement Report was filled out.
   - Improvement reports should not be copied without consent of Risk Management.
   - Any extraneous documentation surrounding the event should be turned in and attached to improvement report to maintain peer protection. Items kept in an employee's possession are not protected by statute and will have to be disclosed in a lawsuit.

2. The department manager or designee will follow-up on any incidents reported concerning patients, visitors or medical staff. This follow-up includes but is not limited to identifying any potential sentinel events and initiating the sentinel event policy and establishing a plan, which addresses the issues surrounding the occurrence. The plan may involve other departments and the formation of Process Improvement Teams with the goal of preventing similar incidents from occurring in the future. The manager will document actions taken and clinical outcomes on the appropriate section of the Improvement Report Form.

   - Incases involving medical devices or equipment resulting in potential or actual injury to the patient or staff, an Improvement Report must be filed, as well as a Safe Medical Device Act Report (Refer to Risk Management).
   - Employee job related injuries/illnesses must be reported by the employee on an Employee Incident/Health Office Report Form and sent with the employee to Emergency Services or to the Employee Health Office. This form must be submitted to the employee Health Department within 24 hours of the incident (see Policy #602 – Transitional Employee Handbook).

3. The department manager has the responsibility to forward all reports to Risk Management with 24 hours. On evenings, weekends, and Holidays, serious occurrences and/or potential sentinel events should be called the Administrative Coordinator. The Administrative Coordinator will determine if Risk Management or the Administrator on-call should be contacted.

4. Risk Management will review all Improvement Reports and assess for opportunities for improvement. The Improvement Report forms and follow-up responses will be kept on file in the Department of Risk Management. The data collected will be analyzed and submitted to the Safety Committee, Hospital Quality Council, and Medical Staff Quality Improvement Committee for review.

Related Policies: Sentinel Event Policy Administrative Manual
Reporting Job Related Injuries/Illness (Policy #6.02 in Transitional Employee Handbook)
Performance Improvement Plan

Supercedes:

Reviewed By: Quality Council 10/27/98
Executive Team 10/14/98, 10/24/01
Administration 12/2012
Risk Management 10/24/01, 10/31/05, 12/2009, 12/2012

Effective Date: 12/2012

Approval: 12/2015

Carol Stoll, Vice President Patient Services — December, 2012 Date

Edward Bruff,
Executive Vice President & Chief Operations Officer — December, 2012 Date

COVENANT HealthCare

IMPROVEMENT REPORT

(1) PRINT LEGIBLY USING BALL-POINT PEN-PRESS FIRMLY
(2) COMPLETE ALL SECTIONS ON BOTH SIDES
(3) DO NOT COPY THIS QUALITY/PEER REVIEW FORM
(4) FORM IS NOT PART OF THE MEDICAL RECORD
(5) SEND TO RISK MANAGEMENT WITHIN 24 HOURS OF EVENT
(6) IF URGENT EVENT OR INJURY, PHONE REPORT IMMEDIATELY TO EXT. 4389

ADDRESSOGRAPH STICKER
Or Patient: Last Name, First Name, Middle Initial, Medical Record Number, DOB, Sex, Other: Name, Address & Telephone

STAFF INFORMATION

NAME (PRINT) _____ POSITION/TITLE _____
DEPARTMENT _____ SUPERVISOR _____
PHONE EXTENSION: _____

RISK MANAGEMENT TO [redacted] DEPARTMENT/[redacted]

FACILITY	LOCATION OF EVENT	CONTRIBUTING FACTORS
DESCRIBE FACTS OF EVENT: (NO OPINIONS)		☐ Communication Issue ☐ Equipment Related ☐ Ordering Error ☐ Physician Related ☐ Staff Related ☐ Patient Non-Compliance ☐ Other

(Improving the efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, respect and caring.)

PHYSICAL EXAM COMPLETED BY PHYSICIAN? ☐ Yes ☐ No	DATE	TIME (24 HOUR)	ATTENDING PHYSICIAN NOTIFIED? ☐ Yes ☐ No	DATE	TIME (24 HOUR)
EXAMINING PHYSICIAN (PRINT)		SPECIALITY	ATTENDING PHYSICIAN (PRINT)		SPECIALITY

EQUIPMENT INVOLVED

EQUIPMENT TYPE: _____
MANUFACTURER ID: _____
MODEL #: _____
SERIAL #: _____
EQUIPMENT STORAGE LOCATION: _____
REPORT SMDA EVENT? ☐ YES ☐ NO _____

MED/IV/BLOOD ADMIN TYPE

Describe:
☐ Medication/Drug Type: _____
☐ IV Solution: _____
☐ Blood Administration: _____
☐ NDC#: _____
☐ LOT#: _____

NA[redacted]

☐ 1 No Injury	☐ 17 Hemorrhage	EXAM:	Type I - No Injury
☐ 2 Not Applicable	☐ 18 Infection/Contagious Disease	☐ Yes ☐ No ☐ N/A	Type II - Bruise or Abrasion
☐ 3 Abrasion, Bruise, Contusion	☐ 19 Infection Site Injury	X-Ray:	Type III - X-ray, No Fx, Pulled IV, Foley, Tubes Out
☐ 4 Adverse Drug Reaction Toxicity	☐ 20 Internal Injury	☐ Yes ☐ No ☐ N/A	Type IV - X-ray, Fx, Transfer to Critical Care
☐ 5 Aggravation of Pre-Exist Cond.	☐ 21 Laceration	LAB:	
☐ 6 Allergic Reaction	☐ 22 Myocardial Infarction	☐ Yes ☐ No ☐ N/A	
☐ 7 Amputation	☐ 23 Neurological Impairment	>LENGTH OF STAY:	
☐ 8 Asphyxia/Anoxia	☐ 24 Puncture	☐ Yes ☐ No ☐ N/A	
☐ 9 Back Injury	☐ 25 Pulmonary Embolism	> TREATMENT NEEDED:	
☐ 10 Burn	☐ 26 Sprain/Strain	☐ Yes ☐ No ☐ N/A	
☐ 11 Concussion	☐ 27 Skin Irritation	REFERRAL TO: _____	
☐ 12 Drug Overdose	☐ 28 Vascular Impairment	TRANSFERRED: _____	
☐ 13 Decubitus Ulcer	☐ 29 Visual Loss Impairment		
☐ 14 Deterioration of Mental Status	☐ 30 Wound Disruption		
☐ 15 Electric Shock	☐ 31 Other:		
☐ 16 Fracture			

[redacted]		TITLE/POSITION	[redacted]
Reviewed in Risk Management By		TITLE/POSITION	DATE REVIEWED

PF00947 (R 1/07)

DEFENDANT'S EXHIBIT 2

IMPROVEMENT REPORT

Opportunities For Improvement & Investigative Statements

COVENANT HealthCare

(Improving the efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, respect and caring.)

[redacted]	WITNESSES [redacted] NAMES)
Is the patient/customer satisfied? ☐ Yes ☐ No	

DESIGN/PLAN FOR CHANGE OR SUCCESS IDENTIFIED	[redacted]	IMPROVING ACTION FOLLOW-UP
	☐ 01 Knowledge	☐ 1 No Action Required
	☐ 02 Communication	☐ 2 Education of Patient or Family
	☐ 03 Motivation	☐ 3 Policy/Procedure Change
	☐ 04 Planning	☐ 4 Equipment Required/Replaced
	☐ 05 Performance	[redacted]
	☐ 06 Resources	☐ 6 To Committee/Team:
Is the patient/customer satisfied? ☐ Yes ☐ No	☐ 07 Supervision	☐ 7 Other: _____
SUPERVISOR NAME (PRINT LEGIBLY) / DATE	☐ 08 Documentation	FOLLOW-UP DATE: _____

ANALYSIS-RISK MANAGEMENT ONLY

[redacted]	RISK PROFILE	DISPOSITION	[redacted]
Agreement with Action? ☐ Yes ☐ No	☐ High Risk	☐ 1 No Further Action	
	☐ High Cost	☐ 2 Send to Clinical Review	
Preventable? ☐ Yes ☐ No	☐ High Frequency	☐ 3 Open PCE File	
	☐ Legal Issue	☐ 4 Open Claim File	
Bills on Hold? ☐ Yes ☐ No	☐ Policy & Procedure Variance	☐ 5 Refer to Legal Counsel	
	☐ Customer/Staff Satisfaction	☐ 6 Mark for Education Schedule	
Call Patient? ☐ Yes ☐ No	☐ Public or Community Issue	☐ 7 To Committee/Team:	
RISK MANAGEMENT NAME (PRINT) / DATE		☐ 8 Other: _____	☐ Other Issue: _____